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MEDICAL MALOCCURRENCE INSURANCE: A FIRST PARTY NO- FAULT INSURANCE PROPOSAL FOR RESOLVING THE MEDICAL MALPRACTICE INSURANCE CONTROVERSY

Medical malpractice liability has been a continuing source of controversy and crisis ever since medical malpractice insurance rates skyrocketed in 1974. The current system finds few defenders among health care providers, injured patients, insurance companies, and even attorneys. Health care providers complain bitterly of enormous malpractice insurance premium costs, diminished insurance availability, and an increasingly heavy barrage of malpractice suits. Insurance companies claim that increased loss ratios and restrictive state regulation have made medical malpractice insurance underwriting unprofitable and burdensome. Plaintiffs complain that the present tort system is an unfair, unpredictable, and cumbersome lottery that delays resolution for years and awards compensation disproportionately to similarly situated plaintiffs. In the face of such expensive, difficult, and unpredictable litigation, even personal injury attorneys are loath to accept any but the most attractive malpractice cases.

Recent tort reforms have proved inadequate to resolve such difficulties. Current proposals unfairly benefit some groups at the expense of others, without treating the medical malpractice system comprehensively.

This Note proposes a novel solution¹ to the medical malpractice conundrum: a patient-derived (first party) “no-fault” insur-

1. Although some approaches come close, no one seems to have quite hit upon the combination of first party, mandatory no-fault insurance. Danzon, for example, discusses the respective strengths and weaknesses of both third party no-fault and an elective contractual system of patient-derived—yet third party—no-fault insurance coverage. P. DANZON, *MEDICAL MALPRACTICE* 208-19 (1985).

Yet in distinguishing no-fault auto insurance plans from no-fault iatrogenic injury plans, Danzon notes in passing that

[i]n no-fault automobile plans, the injured party is compensated without regard to his fault through his own first party insurance. Thus . . . third-party liability

ance system to compensate victims of iatrogenic maloccurrence,² regardless of negligence.³ Basically, this proposal would require patients seeking admission to a hospital or treatment from a physician to purchase an insurance policy covering at least that particular course of treatment or operation,⁴ if they did not already have comprehensive medical maloccurrence insurance.

The policy would be no-fault, in that negligence or fault on the part of the health care providers would be irrelevant; the insured patient would be covered for any adverse medical outcome due to treatment. The causal relationship between medical intervention and adverse medical outcome would be presumed unless the outcome was an unavoidable consequence of a preexisting condition or a reasonably anticipated result of treatment. A patient could purchase an unlimited amount of coverage over the minimum. A range of coverage alternatives would be made available, from a restricted, economic-damages-only policy, to a "full-coverage" policy covering noneconomic damages, such as pain and suffering, up to a specified policy limit.

Part I of this Note examines the broad, underlying themes of tort theory and argues that, in general, the tort system's primary responsibility should be compensation, rather than deterrence of

through tort is replaced by mandatory first party insurance. In the medical context, by contrast, the proposal is to make medical providers liable without regard to their fault. This might more correctly be called strict provider liability, akin to strict liability of employers for work-related injuries under workers' compensation.

Id. at 214.

The obvious has been overlooked: why not apply the no-fault automobile model in all its first party purity? Replacing the third party medical malpractice system with a first party no-fault system combines the respective strengths of the various prior proposals without their weaknesses.

2. As used herein, "iatrogenic" means an injury proximately resulting from the course of medical treatment.

3. It is important to distinguish between "strict liability" and a "no-fault" scheme (though both terms mean awarding compensation without regard to the fault of the defendant). Ideally,

"no-fault" signifies a first party model under which the claimant no longer looks, like a tort plaintiff, to a third party or his "liability" insurer but instead to a non-causal source of compensation whether it be a first party policy covering all occupants of a car (as in the United States) or a specific central fund (as in Saskatchewan or Victoria (Australia)) or branch of the general social security system, as in New Zealand

Fleming, *The Pearson Report: Its "Strategy,"* 42 MOD. L. REV. 249, 260 (1979).

Quite often, however, the term "no-fault" is applied indiscriminately to both first party and third party insurance plans. Cf. P. DANZON, *supra* note 1, at 208-19 (distinguishing no-fault auto insurance from no-fault malpractice insurance proposals).

4. Alternatively, the system might be formulated to allow patients to waive their tort rights in lieu of purchasing such insurance. *But see infra* notes 156-59 and accompanying text.

risk taking. In so far as the production of goods and services causes injury, such losses should be shared and spread as widely and proportionately as possible. Part II discusses the history and nature of the medical malpractice insurance crisis. Part III evaluates the numerous systemic solutions suggested by various commentators. Finally, Part IV proposes a new solution: first party, no-fault medical maloccurrence insurance (MMI).

I. JUSTIFYING COMPENSATION

This Part argues that, as the present tort system produces insignificant loss deterrence, the primary function of modern tort law is cost/loss allocation. The current system should be replaced whenever an alternative system would perform this function more fairly and efficiently.⁵

Any system of compensation must first answer the normative question, "Why compensate *X*?" At present, tort law predominantly gives a fault-based or negligence justification for compensation, but, within the last thirty years, the emphasis has increasingly shifted toward compensating injuries through the mechanism of strict liability.

According to a fundamental, though often overlooked, principle of modern tort law, losses should be distributed as fairly and efficiently as possible. The rise of strict liability is due to recognition of the utility of distributing losses over the widest possible group, which can bear them with the least disutility.⁶ Be-

5. Professor Sugarman makes these proposals:

(1) [E]liminate tort remedies for accidental injuries; (2) build on existing social insurance and employee benefit plans to assure compensation to accident victims in line with compensation provided for other major causes of income loss and medical expense; and (3) build on existing regulatory schemes both to promote accident avoidance and to provide outlets for complaints about unreasonably dangerous conduct.

Sugarman, *Doing Away With Tort Law*, 73 CALIF. L. REV. 555, 559 (1985). This Note disagrees with his limitation of recovery to economic damages such as "income loss and medical expense." *Id.*

6. Strict liability as loss spreading justifies itself economically on the grounds that costs should be allocated so as to cause the least disruption, the least disutility. This can be done in three basic ways—assessing damages (1) over periods of time, (2) over the widest possible audience, (3) against those specific actors who can best afford them (the so-called "deep pockets"), or any combination of these three.

The basic idea of wide cost spreading is the inverse of the theory of the decreasing marginal utility of the dollar—the increasing marginal utility of cumulative losses. Fletcher, *Fairness and Utility in Tort Theory*, 85 HARV. L. REV. 537, 547 (1972). The former states that a particular sum of money is of less real value to an individual the more he has; this is the "deep pockets" theory. The core of strict liability, however,

cause "the real burden of a loss is smaller the more people share it,"⁷ when some members of society suffer more than others, their losses should be shifted to and shared equally with the other members of the community, without regard to fault.⁸

As a form of social engineering,⁹ modern tort law is inevitably concerned primarily with the fair and efficient distribution of social costs, that is, with the spreading of the burdens that devolve upon particular actors or groups of actors in society.¹⁰ Regardless of its particular factual and legal issues, every tort case allocates the immediate burden of an injury among the interested parties, whether leaving it with the plaintiffs or shifting it to the defendants.

Tort law clearly concerns the retroactive distribution of losses, but what of the principle of deterrence, of the prospective control of risks? The concept of deterrence is largely fallacious, both as an empirical and a theoretical matter.¹¹ First, from an empiri-

ought to be the inverse: the less an individual has, the more each sacrifice actually hurts. Properly "distributing a loss 'creates' utility by shifting units of the loss to those who may bear them with less disutility." *Id.* at 547 n.40; see also Calabresi, *Some Thoughts on Risk Distribution and the Law of Torts*, 70 YALE L.J. 499, 517-19 (1961).

7. Calabresi, *supra* note 6, at 517. "The justification for allocation of losses on a nonfault basis . . . is that if losses are broadly spread—among people and over time—they are least harmful." *Id.*; see also Morris, *Enterprise Liability and the Actuarial Process—The Insignificance of Foresight*, 70 YALE L.J. 554, 586-87 (1961). "In place of the entrepreneur's deep pocket we have substituted the pocket of every man. His pocket may not be deep in absolute terms, but it is in relation to the amount taken from it." *Id.*

8. For various perspectives on loss spreading and sharing, see Abel, *A Socialist Approach to Risk*, 41 MD. L. REV. 695 (1982); Calabresi, *supra* note 6, at 517-19; Fletcher, *supra* note 6, at 547; Hutchinson, *Beyond No-Fault*, 73 CALIF. L. REV. 755 (1985).

9. One commentator defines the term "social engineering" as the promotion of efficient behavior. Latin, *Problem-Solving Behavior and Theories of Tort Liability*, 73 CALIF. L. REV. 677 (1985). This definition is too restrictive. Social engineering is more properly viewed as any systematic attempt to promote the common good, rather than merely to resolve disputes. As Professor Owen noted in *Deterrence and Desert in Tort: A Comment*, 73 CALIF. L. REV. 665, 666 (1985), the frequently cited twin "goals" of the tort law, compensation and deterrence, are really only "functions." Compensation, for example, is only appropriate if it furthers the goals of the tort system—goals dictated by "the common good."

10. See Morris, *supra* note 7, at 556: "Clearly, we must accept [these] functional observations Shock losses are spread by way of insurance and through the channels of commerce, resulting in a net social gain. . . . The loss will still be spread, and that is the main thing."

11. Professor Sugarman has argued this point in much greater depth than the scope of this Note allows. His article lists numerous reasons why tort liability actually lacks the deterrent value often ascribed to it: the self-preservation instinct of would-be tortfeasors, ordinary market forces, moral inhibitions, government regulation, ignorance, incompetence, threat discounting, high stakes for tortious behavior, small penalties, and liability insurance. Sugarman, *supra* note 5, at 561-74. The approach here places more emphasis on what Sugarman calls "market imperfections," the argument that "tort damages will

cal standpoint, compensating injuries does not deter because no market for injury exists. The jury assesses the injury done, not the cost of prevention, in awarding damages. Even so, the tort system compensates sporadically, at best: "the extremely low probability of any sanction virtually nullifies the possibility of a general deterrent effect."¹²

Furthermore, negligence-based liability will only deter "high attention" risk creators.¹³ Deterrence is unlikely to occur where the risk creator is unaware of both the risk and the deficiency of his present level of knowledge. Thus, where the injuries occurred when the danger was unknown, as in cases involving latently carcinogenic substances, deterrence plays no role.¹⁴

In such cases, courts award compensation by applying the doctrine of strict liability. In their desire to compensate the victims of undeserved injuries, courts have accepted a variety of novel, elaborate strict liability arguments, such as market share or enterprise liability. Such cases dispense with proof of some traditionally essential requirements of causation, as well as proof of negligence.¹⁵

Finally, because tort law does not interfere with profit return over time, it fails to provide actors with a financial incentive to

not lessen profit because the defendant will effortlessly shift those costs to its consumers." *Id.* at 573.

12. Abel, *supra* note 8, at 698-99.

13.

The term "high-attention risk" is used to denote an accident context in which a category of actors meets all of the requirements for effective cost-minimizing decisionmaking: typical actors must understand material risks and applicable liability doctrines, must pay attention to risks and legal rules while engaged in risky conduct, and must assess the costs and benefits of alternative choices when subject to liability for a designated type of accident loss. If any of these conditions is absent in a given accident setting, the risk should be characterized as "low attention."

Latin, *supra* note 9, at 697 (footnote omitted).

14. Often, in fact, no activity remains to deter: the corporation may be bankrupt, the dangerous product or condition no longer permitted. The growth of government safety regulation, as inadequate as it remains, is further evidence of tort law's poor record as a deterrent. Abel, *supra* note 8, at 699.

This is not to say that tort liability does not induce any deterrence, particularly on the part of individual actors motivated by the normative sting and adverse publicity of a liability judgment. Rather, there is "little reason to believe that tort law today actually serves an *important* accident avoidance function." Sugarman, *supra* note 5, at 560. Furthermore, as Sugarman also notes, to the extent that the imposition of liability does generate preventative measures, much of the efficacy of tort law deterrence may be offset by such socially undesirable responses as "defensive medicine." *Id.* at 581-83.

15. See generally Note, *The Application of a Due Diligence Requirement to Market Share Theory in DES Litigation*, 19 U. MICH. J.L. REF. 771 (1986) (discussing elements of a "market share" products liability claim).

avoid risks.¹⁶ Under a system of tort liability, accident costs are insufficiently internalized by manufacturers, who pass the costs of judgments, improvements, and insurance onto consumers in the form of higher prices. Even in the short run, tortfeasors are insulated from judgments either by insurance or insolvency. In effect, the consumer pays for the cost of insuring himself against injury.¹⁷

Because the producer-defendant class does not internalize the social costs of productive activity, such costs are ultimately distributed solely among the consumer-plaintiff class, and will not diminish the accumulation of capital within the producer-defendant class.¹⁸ Therefore, costs should be spread as widely among consumer-plaintiffs as possible, in order to maximize efficiency. According to the law of the increasing marginal utility of cumulative losses, to leave the burden solely on those members of the class who are unfortunate enough to suffer injury is less efficient than to spread the burden among all the members of the community.¹⁹

The shortest distance between two points is a straight line. First party MMI simply incorporates the observation that the

16. Admittedly, the wild card in this premise could be foreign competition, from countries whose workers and consumers must bear their own individual losses—allowing foreign business to produce even more cheaply.

17. Fleming, *supra* note 3, at 263. Furthermore, even in those markets that are relatively price inelastic, "the extremely low probability of any sanction virtually nullifies the possibility of a general deterrent effect." Abel, *supra* note 8, at 698-99. The tort system has been labelled a system of "compulsory insurance." P. DANZON, *supra* note 1, at 153.

18. Thus, where liability is denied, the victims must bear the losses themselves. This is loss distribution on the basis of bad luck. If liability is found, whether under the regime of negligence or of strict liability, producer-defendants generally avoid internalizing the costs engendered by their activities—adverse judgments, increased production costs, or higher insurance premiums—by charging higher prices, paying lower wages, or paying fewer taxes.

What of the defendant who is unable to spread his loss or increased cost? For example, how does someone who causes an accident while on a Sunday drive pass his increased insurance cost back to the consumer-plaintiff class? The answer is that in his capacity as an ordinary defendant, not a producer-defendant engaged in the process of producing goods or services, the defendant is liable for what might be termed a "reciprocal risk." See Fletcher, *supra* note 6, at 546-47. When consumers injure each other, the burden will necessarily fall upon members of the consumer class, regardless of which side wins.

When a producer injures people in the course of or as a result of his productive activity, his costs may seem to increase relative to those of his competitors. Statistically, however, within the same trade or industry, every producer should experience his "fair share" of liabilities. Over time, injuries should average out evenly enough throughout the industry to raise everyone's costs uniformly. Thus, the producer's costs can eventually be passed on to consumers, even in a competitive market. In the meantime, temporary losses can be carried forward for tax deductions.

19. See *supra* notes 6-7 and accompanying text.

patients, as consumers of health care, are actually paying for their own insurance anyway, through increased medical fees.²⁰ Instead, health care consumers might fairly and more efficiently purchase their own insurance directly. Doing so would save both health care providers and patients substantial transaction costs, give patients greater autonomy, and provide fair compensation for a broader range of victims. This is the premise underlying first party MMI.²¹

II. CRISIS? WHAT CRISIS?

This Part examines the recent history of the medical malpractice insurance predicament and suggests that its most salient feature is the time differential involved in passing increased premium costs to patients through higher medical costs. This problem would be solved if patients carried first party MMI because providers would no longer be subject to significant malpractice liability and would no longer have to carry primary liability insurance.

A. *The Cycle of Crises*

In 1974, the issue of medical malpractice exploded across America as health care providers saw their medical malpractice liability insurance premiums increase up to 500% virtually overnight.²² The resulting uproar from the medical community, in-

20. This has been termed the "pass-through effect." See Zuckerman, Koller & Borbjerg, *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, LAW & CONTEMP. PROBS., Spring 1986, at 85, 106-07 (discussing pass-through of premium costs to patients, and noting study showing that 75% of premium increases are recovered from patients); see also Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580, 591-92; Tancredi & Baroness, *The Problem of Defensive Medicine*, 200 SCIENCE 879 (1978) ("[Malpractice insurance] costs are, to a large measure, passed on to the patient, and inevitably affect the overall cost of medical care.").

21. See Robinson, *Rethinking the Allocations of Medical Malpractice Risks Between Patients and Providers*, LAW & CONTEMP. PROBS., Spring 1986, at 173, 181-82. See generally P. DANZON, *supra* note 1, at 168 ("The . . . argument that would design tort awards solely with a view to efficient compensation is ultimately an argument for abolishing the tort system altogether.").

22. P. DANZON, *supra* note 1, at 85. The sheer size of the health care industry challenges the imagination. The health care industry currently represents well over 10% of the gross national product. In 1982, expenditures on health care were estimated to be \$322.4 billion per year and growing at a rate of 12.5% annually. Neubauer & Henke, *Medical Malpractice Legislation*, TRIAL, Jan. 1985, at 64, 67. In 1983, health care providers spent roughly \$3 billion on liability insurance, of which physicians provided \$1.7 bil-

cluding unprecedented mass physician walkouts,²³ began a national debate on the issue that continues unabated. Efforts to resolve the controversy resulted in numerous state regulatory reforms and initiatives, such as Joint Underwriting Associations (JUA's),²⁴ as well as substantial state tort law changes.²⁵ Congress has considered numerous proposals, some far-reaching, including the Federal Medical Malpractice Insurance Act of 1975,²⁶ and the Alternative Medical Liability Act of 1985,²⁷ whose descendant was debated through 1986.²⁸

Various factors explain the sudden malpractice premium increases. One commentator argues that the premiums charged for the period from 1969 to 1974 were grossly inadequate.²⁹ First, the insurance companies undercharged according to their own 1969 loss estimates, so that by 1975 undercharging alone required a rate increase of fifty-eight percent. The insurers severely underestimated their loss ratios, however, so that by 1975 a minimum 300% premium increase was required.³⁰ Thus, poor forecasting methods, since corrected, which overlooked increased

lion. *Alternative Medical Liability Act: Hearing on H.R. 5400 Before the Subcomm. on Health of the House Comm. on Ways and Means*, 98th Cong., 2d Sess. 45, 49 (1984) [hereinafter *AMLA Hearings*] (statements of Congressmen W. Henson Moore and Richard Gephardt). A 1985 report by the Michigan Bureau of Insurance placed the nation's health care bill at \$350 billion, with malpractice premiums accounting for one or two percent of the cost. MICHIGAN INS. BUREAU, DEPARTMENT OF LICENSING & REGULATION, MEDICAL MALPRACTICE ISSUES 1 (1985) [hereinafter *MICH. INS. BUREAU REPORT*].

23. Throughout much of California, doctors staged a month-long protest strike against rising malpractice insurance rates. See Weinstein, *Coast Doctors End Strike, Agree on Malpractice Pact*, N.Y. Times, May 29, 1975, at 1, col. 4.

24. JUA's are a kind of "assigned risk pool," which companies writing insurance in the state are required to join, providing emergency insurance in the absence of adequate voluntary coverage. FUND FOR PUB. EDUC., AMERICAN BAR ASS'N, LEGAL TOPICS RELATING TO MEDICAL MALPRACTICE 1 (1977) [hereinafter *ABA REPORT*] (report submitted to U.S. Dep't of Health, Educ. & Welfare Health Care Sys. Div.); see also P. DANZON, *supra* note 1, at 112.

25. See P. DANZON, *supra* note 1, at 35. For a state by state analysis of tort law changes as of 1984, see *AMLA Hearings*, *supra* note 22, at 138-66; see also Strasser, *Both Sides Brace for Tort Battle*, Nat'l L.J., Feb. 16, 1987, at 1, col. 1.

26. This proposed legislation was actually a group of closely related bills: S. 482, 94th Cong., 1st Sess. (1975) (National Medical Malpractice Insurance and Arbitration Act of 1975); S. 188, 94th Cong., 1st Sess. (1975) (Federal Medical Malpractice Insurance Act of 1975); S. 215, 94th Cong., 1st Sess. (1975) (National Medical Injury Compensation Insurance Act of 1975). Cf. H.R. 13870 and S. 3286, 93d Cong., 2d Sess. (1974) (Comprehensive National Health Insurance Act of 1974).

27. H.R. 5400, 98th Cong., 2d Sess. (1984).

28. H.R. 3084, 99th Cong., 1st Sess. (1985).

29. P. DANZON, *supra* note 1, at 98-103.

30. *Id.* at 99.

claim frequency explain much of the rate inadequacy from 1969 to 1974.³¹

Although highly concentrated, the insurance market was—and still is—extremely competitive, another factor that contributed to rate inadequacy.³² Several aggressive companies began underwriting malpractice insurance, and without the “long tail” of previous claims, these companies quickly acquired large shares of the market.³³ In addition, medical societies exercised considerable downward pressure on insurance rates.³⁴

Few anticipated the increase in malpractice litigation that occurred.³⁵ This increase was largely due to demographic factors such as population growth, urbanization, greater utilization of

31. *Id.* at 99-100; see also R. Fleming, Final Report to Governor James J. Blanchard on the Subject of Health Care Provider Malpractice and Malpractice Insurance 14, 16 (Dec. 17, 1985) (discussing reasons for the rise in malpractice insurance premiums) (copy on file with U. MICH. J.L. REF.).

32. P. DANZON, *supra* note 1, at 95.

33. The “long tail” refers to the fact that while there is a “lag time” between purchase of the policy and the payment of claims against it, claims will continue to be made and paid for many years after the policy year. See P. DANZON, *supra* note 1, at 102.

34. Much of the medical malpractice insurance is written as group coverage, arranged directly between the insurer and the state medical society. Through its organized strength and control over the data base, the medical society is a substantial check on the monopoly power of the insurer. If one company's rates are too high, the medical society can either take the entire program to another insurer, or insure itself by beginning a physician owned mutual insurance fund. Such mutuals have been formed throughout the country and now underwrite over 40% of the market. P. DANZON, *supra* note 1, at 86.

35. “[T]he principal determinants of premiums are the frequency of the claims (i.e., how often they are filed) and the ‘severity’ of the claims (i.e., how much, on average, each claim will cost).” R. Fleming, *supra* note 31, at 13.

Although most commentators point out that claim severity and frequency are continually rising, the rates fluctuate, and adequate data are hard to find. According to Danzon, however, a “surge in malpractice claim frequency in the late sixties and early seventies culminated in the insurance crisis of 1975.” P. DANZON, *supra* note 1, at 60. Claim frequency levelled off or fell in the late seventies, but since 1977 it has been increasing at an estimated rate of 12% per year. *Id.* at 59-65, 90.

From 1971 to 1978, cost per paid claim (awards and settlements) increased 12.4% per year for physicians and surgeons, and 18.9% per year for hospitals. Between 1975 and 1978, severity grew by 30% for the average state. Severity may fluctuate wildly, however, among states and even particular insurance companies, due to the relatively small risk pool: an unusually large award in one year can significantly increase average and total malpractice claim losses. *Id.* at 65.

health care facilities, and the increased number of providers.³⁶ It has also been blamed on liberal courts and generous juries.³⁷

Insurers were willing to accept low rates, perhaps hoping that the cumulative difference could eventually be recouped in a later, more favorable insurance market, or through premium investment return. Unfortunately, in 1974, stock prices dropped sharply over the course of only a few months, causing substantial losses to the insurance industry's investments, while underwriting losses were reaching record levels.³⁸

Rising claim costs,³⁹ the cumulative inadequacy of insurance rates, and the sudden loss of capital reserves all combined to trigger "the filing of rate increases of several hundred percent in

36. See P. DANZON, *supra* note 1, at 72-75. Claim frequency increases if the incidence of people being injured increases, if the incidence of injured people filing claims increases, or if the incidence of both injuries and claims per injury increase. *Id.* at 65; see also Zuckerman, Koller & Borbjerg, *supra* note 20, at 93-98.

The risk of injury due to negligent or non-negligent medical care is significant. One 1974 California study found that "about one in twenty hospital inpatients suffers an injury and about one in 125 has a legal claim of malpractice." *Id.* at 94. Yet, according to Danzon, as of 1974, only one in 10 incidents of malpractice resulted in a claim, of which one in 25 received compensation. Even for serious injuries, at most one in seven patients filed claims. Assuming a steady 12% increase in claim frequency and no increase in the rate of injury, "a rough current estimate is that only 1 in 5 incidents of malpractice gives rise to a malpractice claim. Thus the cost of malpractice—the cost of injuries due to negligence—is probably still several times greater than the cost of malpractice claims." P. DANZON, *supra* note 1, at 25; see also R. Fleming, *supra* note 31, at 10 ("[P]atients are frequently unaware that an adverse clinical event is the result of provider negligence and thus avoidable." (citing studies that report from 1 in 6 to 1 in 20 malpractice incidents lead to claims)).

37. Courts have evolved new theories of liability that permit recovery where formerly denied. Juries are arguably more aware of the defendant's insurance deep pocket, and more willing to award large sums. The publicity about high awards encourages further claimants and gives juries precedents for even higher damage awards.

In the medical malpractice area, hospitals lost their traditional charitable immunity, see, e.g., *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), and were increasingly held responsible for the quality of its staff doctors, who had traditionally been considered independent contractors, see, e.g., *Purcell v. Zimbelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972). The traditional "locality rule," judging the performance of medical professionals by the standards of their own or similarly situated communities, came under increasing attack by proponents of "national standards" or "specialty-wide" standards. See *Robbins v. Footer*, 553 F.2d 123 (D.C. Cir. 1977); *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 276 Md. 187, 349 A.2d 245 (1975); *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968).

38. P. DANZON, *supra* note 1, at 105-07. With the premium/capital ratio reaching 4:1 at some major carriers, "by December 1974, a 25 percent error in setting premiums" could result in bankruptcy, and "on the basis of past experience, an error of that magnitude was far from unthinkable." *Id.* at 107.

39. Inflation drove up costs in general. In May 1974, the Nixon administration's Economic Stabilization Program price controls were lifted. This released pent-up market forces, resulting in runaway inflation. See Rockoff, *Price & Wage Controls in Four War-time Periods*, 41 J. ECON. HIST. 381 (1981).

Sudden inflation, of course, greatly increased the nominal cost of insurance, thereby

1974-75."⁴⁰ Uncertainty as to risk exposure and frustration with the generally hostile state regulatory response⁴¹ led some insurers to cut back on underwriting activities or to leave the market entirely, thus causing an "availability crisis."⁴²

The "crisis" of 1974 and 1975 had largely abated by 1976, but the calm was only temporary.⁴³ As interest rates, and thus, premium investment income, remained at record high rates at the end of the seventies and beginning of the eighties, premium rates remained stable or even declined; but as interest rates dropped sharply in 1984, the continuing severity of premium loss ratios sparked the current round of the medical malpractice crisis.⁴⁴

B. *The Nature of the Malpractice Insurance Crisis*

The insurance industry is cyclical because it is interwoven with the general business cycle through investment of its premi-

adding to the crisis atmosphere. This is merely another example of general economic conditions affecting the malpractice insurance industry.

40. P. DANZON, *supra* note 1, at 107.

41. "[T]he percentage of the requested increase actually approved fell from 91 percent in 1973 to 67 percent in 1975. . . . By 1975, 18 states had approved rates that were 161 percent below the recommended ones and the remaining 30 states had rates that were 70 percent too low." *Id.* at 101.

42. "Where regulators have intervened to control rates, the result has been the typical response to price control: a contraction of supply." *Id.* at 113. Since "[r]egulators reflect pressures from their constituents," inadequate rate increases resulted largely from the medical profession's opposition to any increases—an opposition hardened by awareness of the medical profession's relatively strong bargaining position. *Id.* at 102.

43.

Even though the immediate crisis seems to have abated, the efforts which were made in 1975 and 1976 have barely touched the underlying problems, which have to do with aspects of health care delivery and medical discipline, as well as the nature of the tort-insurance system itself.

The need is for a massive and sustained effort to develop ways to deal successfully with the underlying problems. Unless this occurs, it is likely that there will be frequently recurring medical malpractice crises in the future.

ABA REPORT, *supra* note 24, at viii.

44. See R. Fleming, *supra* note 31, at 16-17; see also P. DANZON, *supra* note 1, at 86 ("Rate increases of 20 and 30 percent a year have been sought since 1982. . . . [I]n June 1983 [insurers' loss ratios] . . . exceeded 150 percent."). But see Strasser, *supra* note 25, at 1, col. 3, 40, col. 2 (reporting that with 1986 profits up 625% "the 'insurance crisis' . . . wave now has crested Insurance is more available and its cost is increasing more slowly."); R. Fleming, *supra* note 31, at 4 (stating that in spite of increased premium costs, reports of a new malpractice insurance availability crisis are exaggerated; "there is little evidence of widespread availability problems.").

ums and its real profits.⁴⁵ Because of "lag time" or delay between receipt of premiums and payment of claims, insurance companies are able to make substantial investment profits to supplement premium income.⁴⁶

Insurers anticipate that surpluses during some periods will offset losses during others, to provide an adequate and stable profit over time. Although periods of unexpectedly high loss ratios will eventually result in higher premiums, receipt of higher premiums raises capital reserves, which provides both increased investment income and greater ability to withstand high premium loss ratios. In a competitive insurance market, increases in premium investment income allow for premium decreases, which continue until losses threaten the premium/capital ratio.⁴⁷

The most striking fact about the alleged malpractice crisis is that the real, or inflation adjusted, cost of malpractice insurance has not increased over time. The malpractice insurance crisis is a myth.⁴⁸ Premium increases from 1973 to 1976 offset relatively

45. "The unprecedented jump [in insurance prices] last year came because financial and market forces had earlier driven prices to unprecedented lows in what is always a cyclical industry." Strasser, *supra* note 25, at 40 (quoting D. Whiteman, Congressional Research Serv. economist); see also R. Fleming, *supra* note 31, at 16.

46. P. DANZON, *supra* note 1, at 105.

47.

The tendency [is] for insurance prices to lag and then lead claim costs and hence to produce cycles in underwriting profits Since the huge 1975 premium increases, malpractice insurance rates have either declined or remained stable while the combined loss ratio (claim costs plus all expenses, relative to premium) has risen from 94 percent in 1977 to more than 170 percent in 1983.

P. DANZON, *supra* note 1, at 103.

48. The debate over the artificiality of the crisis largely centers on whether or not insurers lose money on premiums; or, whether insurers and allied provider groups have deceitfully engineered the current crisis atmosphere in order to obtain windfall profits from loss-limiting tort reforms, while continuing to increase premiums. See, e.g., Neubauer & Henke, *supra* note 22, at 64-69. "[T]he medical and insurance industries hoodwinked the legislatures. The malpractice 'crisis' evaporated as quickly as it was manufactured" *Id.* at 65; see also *AMLA Hearings*, *supra* note 22, at 123-25 (statement of C. Thomas Bendorf, Executive Director & Director of Public Affairs, Association of Trial Lawyers of Am.) (testifying that despite a 25-year underwriting loss of \$13.8 billion, insurer assets increased from \$23 billion to \$197 billion; from 1975 to 1982, insurers took in premiums totalling \$10.62 billion and paid claims worth \$2.05 billion, leaving reserves of \$7.978 billion and earning investment income of \$2.755 billion).

These are specious arguments, as are antithetical insurance industry claims of vast losses. Capitalism is characterized by counterbalancing peaks and troughs, which yield a steady return of profit over time. Over a period of 25 years, large industries either accumulate substantial assets from profits—or perish. The insurance industry is no exception. Between 1976 and 1982, a surplus period, premiums actually fell. With interest rates and premiums low, but loss ratios at typical highs, premium prices must increase. See *supra* note 44.

Furthermore, the argument that \$35,000 premiums are unjustified with the average claim per doctor at only \$2300 per year is misleading. *AMLA Hearings*, *supra* note 22, at

low premiums from 1969 to 1972. The increases since 1983 follow the declining rates of the 1976 to 1982 period.⁴⁹ Furthermore, provider income growth more than keeps pace with inflationary insurance cost increases.⁵⁰

The major source of the current media and legislative interest in the malpractice issue is the "reaction of the [health care] provider community to [rising] premiums."⁵¹ Providers are up in arms over the volatility of malpractice insurance rates.⁵² The crux of the matter, however, is not rate volatility per se, but the inefficiency of health care providers as cost spreaders.

123-24. Given the highly skewed nature of malpractice rates, the small policyholder pools involved, and the long tail of future claimants, the low per doctor claim average is irrelevant.

Finally, price-fixing allegations are unfounded; though concentrated, the malpractice insurance industry is competitive. See P. DANZON, *supra* note 1, at 103.

49.

[B]etween 1976 and 1985, malpractice insurance premiums charged by the majority of insurers did not generally increase in real (i.e., inflation-adjusted) terms. In fact, within most specialties, the inflation-adjusted costs of malpractice premiums for most physicians decreased, in some cases substantially.

. . . For the majority of insurers, the trend in [malpractice] premiums shows that between 1976 and 1982, premiums declined by about half in real terms. Between 1982 and 1985, premiums increased dramatically, so that, in real terms, 1985 levels are generally at or slightly below 1976 levels.

R. Fleming, *supra* note 31, at 15 (findings 15 & 16).

50. "For physicians, malpractice insurance premiums average approximately 3 percent of gross income (1982) ranging from 1 percent to 2 percent for general practitioners, up to 6 percent for high risk surgical specialties. *These percentages have increased only slightly since 1970.*" MICH. INS. BUREAU REPORT, *supra* note 22, at 1 (emphasis added).

According to one commentator, physician income growth "has been spectacular. I doubt that any other occupational category has ever achieved such a rapid rise in income during so short a period of time." Moore, *Doctor's Work Ethic*, 17 J. Soc. Hist. 547, 560 (1984). The median net income of nonsalaried physicians has greatly increased since World War II: from \$8,073 in 1945, to \$22,100 in 1959, \$41,500 in 1970, and \$60,000 in 1978. *Id.* at 559.

In fact, "doctors' fees rise by 9.1% for every 100 percent increase in premiums when these premiums represent only 4 percent of physicians' total operating expenses." MICH. INS. BUREAU REPORT, *supra* note 22, at 6. Normally, one would expect a 100% increase in a cost component accounting for 4% of total expenses to increase total expenses by only 4%. The excess price increase reimburses the provider for the opportunity cost of advancing the malpractice premium money, though in reality this is simply a misallocation. See Zuckerman, Koller & Borbjerg, *supra* note 20, at 106-07; see also *infra* notes 63-64 and accompanying text.

51. R. Fleming, *supra* note 31, at 16.

52.

It seems reasonable to suppose that if these rates had increased gradually and incrementally over the past decade, as the claims experience would seem to have required, then those providers who have been confronted with the large premium increases of the recent past would be far less concerned, though not indifferent, to the situation.

Id.

Premium costs, like all other health care costs, are ultimately borne either directly by health care consumers as patients or indirectly by taxpayers.⁵³ Furthermore, federal taxpayers subsidize employer-financed health insurance benefits⁵⁴ and fund enormous public health care expenditures, including Medicare⁵⁵ and Medicaid,⁵⁶ the federal government's twin programs to subsidize health care for the elderly and poor.⁵⁷

The problem is that medical fees are "sticky in the short run. . . . [I]nfrequent large premium increases are more costly" to providers, particularly physicians, "than an equivalent series of small increases," for they are more difficult to recoup.⁵⁸ When a provider is forced to pay a large, immediate premium increase, she is forced to dip into her resources until she can pass the full extent of the premium increase on to her patients. She loses money on that component of her gross costs, which in turn reduces her gross profit margin on services rendered. A large, abrupt increase in malpractice premiums burdens those providers suffering cash flow problems. The provider may have difficulty raising large, lump sum payments for malpractice insurance.

Providers feel comparatively little competitive pressure on their prices because of both the oligopolistic nature of the health

53.

[H]owever risks are allocated, the insurance system passes costs through to patients and the community at large. Indeed, because of this pass-through of costs, it is questionable whether it makes much difference whether physicians are liable or the loss is left to lie with patients; either way, the public will ultimately bear the costs of such risks. . . . [P]lacement of liability might make a difference in how (and how well) the risk is administered.

Robinson, *supra* note 21, at 182; see also P. DANZON, *supra* note 1, at 131-32 (noting that physicians bear only a small fraction of the costs of malpractice insurance and prevention, and that insurance premiums are tax-deductible).

54. Under federal tax provisions, employers can deduct the cost of their employee health insurance plans, and employees generally can exclude both health insurance benefits and payments received through such benefits (other than those related to absence from work) from taxable income. Treas. Reg. §§ 1.105-3, 1.106-1, 1.162-10 (1960).

55. 42 U.S.C. §§ 1395-1395zz (1982 & Supp. III 1985).

56. 42 U.S.C. §§ 1396-1396q (1982 & Supp. III 1985).

57.

To a large degree, massive governmental and private health insurance funding of health care . . . make it feasible for physicians and hospitals to pass cost increases along to patients. In federal year 1975, for example, third party sources paid 92% of per capita hospital costs and 64.5% of per capita physicians' costs.

ABA REPORT, *supra* note 24, at 72 n.125.

58. P. DANZON, *supra* note 1, at 103.

care industry,⁵⁹ and the high demand for health care services.⁶⁰ This combination of high demand and oligopolistic structure is both a blessing and a curse.

First, prices in an oligopoly are rather inflexible and tend to fluctuate incrementally.⁶¹ Second, because the demand for

59.

A . . . factor upon which analysts of the health-care marketplace have focused is the distortion of the normal supply and demand relationship. One distortion occurs because consumers are not and cannot be knowledgeable about their actual medical needs, and must rely upon their physicians as "purchasing agents" for health care. The physician, aware that third-party payment is guaranteed and that providing additional care to the patient normally results in additional income to the provider, has little or no incentive to withhold medically justifiable care. . . .

. . . [C]onventional competitive forces do not work freely in the health-care market. Physicians have traditionally resisted alternatives to fee-for-service practice and shunned colleagues who have worked as employees of corporations or of prepaid group practices. Organized medicine has steadfastly opposed advertising to the public by individual physicians or by groups, and has imposed sanctions on errant doctors. Entry to the profession has, of course, been restricted by means of licensing and certification.

Comment, *Reagan Administration Health Legislation: The Emergence of a Hidden Agenda*, 20 HARV. J. ON LEGIS. 575, 578-79 (1983) (footnotes omitted).

In the oligopolistic health care industry, providers possess "the ability . . . to raise prices and simultaneously ensure that demand increases enough to support even rapidly growing supplies." Roberts & Bogue, *The American Health Care System: Where Have All the Dollars Gone?*, 13 HARV. J. ON LEGIS. 635, 651 (1976); see also Comment, *supra*, at 578 n.20.

Patients generally choose providers on the basis of location, specialty, and referrals, rather than prices. Many communities harbor few doctors in any particular specialty and contain only a small number of hospitals. Because staff privileges typically do not extensively overlap, consumer choice is restricted even further. See Roberts & Bogue, *supra*, at 658-59.

Reputation supplants price as "a decisive factor governing the demand for [a provider's] services." Moore, *supra*, note 50, at 555. This is because "large segments of the public want the best possible medical care." *Id.* at 559.

In addition, with health insurance so prevalent—"an estimated ninety-five percent of Americans currently have some form of health insurance coverage"—health care consumers have little financial incentive to shop around. Comment, *supra*, at 577-78 (footnotes omitted); see also *supra* note 57.

60.

In medical care . . . it may well be the case that, because of third party payment and consumer attitudes, demand is relatively rather insensitive to prices at current average price levels (*i.e.*, an increase in price results in little or no reduction in the quantity of services demanded by consumers, so that the demand curve is almost vertical).

Roberts & Bogue, *supra* note 59, at 665 (footnote omitted); see also Moore, *supra* note 50, at 560 ("[T]he medical profession provides services—or commodities—for which the potential demand is in our culture extraordinarily powerful: escape from death and pain.").

61. According to Professor Calabresi:

[In an oligopoly,] prices tend to be very "sticky." Each firm knows that if it cuts prices in an attempt to increase its share of the market all the others will follow, and nothing will have been gained. Similarly, each firm fears that a price rise on

health care services is strong and relatively inelastic, providers can artificially increase prices without significantly decreasing demand for their services.⁶² As a basic human need, demand for health care remains impervious to all but the most substantial price increases. Though not vertical, the health care demand curve is steep enough to tolerate modest, yet continuous, cost increases.⁶³ These steady, incremental increases eventually enable providers to completely shift their costs forward to patients; the problem is that in the meantime, the provider must bear the burden of sudden increases in his own costs, such as increased malpractice premiums.

In sum, providers accept premium decreases without commensurate cost decreases, but respond to premium increases not by increasing the cost of their services, but by incrementally increasing both demand and prices, not realizing that they are ultimately insulated from premium increases. If providers had the financial resources to weather periods of sharp premium increases, they would recoup their losses when their real insurance costs declined as a result of a favorable economy.⁶⁴ The current

its part will not be followed by the other firms, and that this will leave the price-raiser high and dry . . . Profits would decline, . . . but no one would leave the industry since . . . the oligopoly structure probably guarantees more profits than could be made elsewhere.

Calabresi, *supra* note 6, at 512 (footnote omitted).

62. See Roberts & Bogue, *supra* note 59, at 658-63. Health care costs increase regardless of malpractice insurance costs. Because "technical change does not increase productivity" in the medical industry, providers maintain their relative standards of living by artificially inflating costs relative to the rest of the economy, whether by periodically raising prices, or by performing unnecessary medical procedures and generally overutilizing provider resources. *Id.* at 659.

63. "If demand remains stable, an industry cannot raise its prices without also decreasing its sales. The extent of this decrease depends upon the slope of the demand curve. If it is relatively steep, changes in price will be accompanied by relatively small changes in volume." Morris, *supra* note 7, at 585. According to Professor Robinson,

[I]n markets characterized by inadequate information and inadequate competition, the manufacturer will have some freedom to pass on . . . inefficiently incurred costs [in the form of higher prices]. But few commercial markets permit the freedom to pass on inefficiently incurred costs to an extent permitted by the health care market. Third-party payments for health care costs significantly lessen market constraints on health care expenditures.

Robinson, *supra* note 21, at 178.

64. Because of a ratchet effect, providers never lower their prices outright, regardless of premium decreases—which are largely due to premium investment income during profitable economic conditions. Instead, they wait until inflation has narrowed the gap between what was charged and what should have been charged, relative to the decrease in the insurance component of their overall costs. In the meantime, providers essentially enjoy windfall profits. With a sudden premium cost increase, however, the providers suffer a decrease in profits, since fee rates are "sticky" and can only be increased gradually. Providers then publicly complain, not realizing that this trough is the natural corollary

malpractice insurance uproar is thus a function of (1) shallow provider financial resources; (2) the requirement of incremental price increases; (3) distorted provider perception of the overall favorable situation, in the face of periodic hardship; and (4) overly optimistic provider expectations resulting from periods of relative prosperity.

C. *The Litigation Problem*

Few, if any, would retain the current liability system without modification. Although actually maintaining their real income levels over time, doctors complain of insurance cost increases, as well as of the frustration, hardship, and extra medical costs engendered by tort litigation. Similarly, insurance companies complain of falling profits and rising loss ratios⁶⁵ in a bid to obtain rate increases from state regulators.⁶⁶

Plaintiffs' attorneys bemoan the unpredictability of outcomes, the risk to firm capital tied up in litigation expenses, and the paucity of prompt settlements.⁶⁷ Defense attorneys complain of the unpredictability of "emotional" juries, and generally adopt the views of their insurer clients.⁶⁸

Of course, those who really bear the brunt of the tort system's costs are those who lack an organized lobby to push and publicize their interests—health care consumers.⁶⁹ They face a system

to the earlier peak. Eventually, providers recoup even more than their temporary losses, and the cycle repeats.

65. See *supra* note 48.

66. See *supra* notes 40-42 and accompanying text.

67. See generally L. CHARFOOS, *THE MEDICAL MALPRACTICE CASE* (1977) (most plaintiffs' attorneys are selective and reluctant to accept malpractice cases absent clear liability and serious injury).

68. See, e.g., *AMLA Hearings*, *supra* note 22, at 110, 111 (statement of Joseph Metzger, Esq.).

69. The system is particularly biased against the poor and elderly. They can least afford high-quality medical care but are most likely to need it. Abel, *supra* note 8, at 717; Abel, *£'s of Cure, Ounces of Prevention* (Book Review), 73 CALIF. L. REV. 1003, 1006-07 (1985) [hereinafter Abel, *Review*] (reviewing D. HARRIS, M. MACLEAN, H. GENN, S. LLOYD-BOSTICK, P. FENN, P. CORFIELD & Y. BRITTAN, *COMPENSATION AND SUPPORT FOR ILLNESS AND INJURY* (1984)). Inability to afford adequate health care leaves the poor more susceptible to malpractice injuries; and, because the poor lack sufficient financial resources, such injuries are more difficult for them to absorb without ample compensation. Yet poor and elderly malpractice victims are much less likely to bring claims. Abel, *Review, supra*, at 1006; cf. P. DANZON, *supra* note 1, at 74 (although more susceptible to injury, elderly are less likely to sue, primarily because they receive smaller awards).

The poor plaintiff finds the law of malpractice biased against him precisely because of the poverty that forced him or her to obtain substandard medical care in the first place. In determining the standard of care to apply to a defendant, "courts have considered

that is unbearably slow and capricious in compensating victims, and does little to control risks. Although both sides must endure the pain of prolonged litigation and uncertain outcomes, the plaintiff is frequently in desperate financial, emotional, and physical condition. He or she may suffer through years of stressful litigation, only to lose at trial.⁷⁰

The evils of tort litigation—particularly medical malpractice tort litigation—are well-documented. Key problems cited by critics include the delay⁷¹ and expense⁷² of resolving claims. Furthermore, the tort system has been characterized as a lottery because of its unpredictability and tendency to award disproportionate compensation to similarly situated plaintiffs.⁷³

The present situation is as distressing to health care providers as it is to most consumers. At least one in four physicians will be sued for malpractice each year; litigation is even more likely for

socio-economic factors such as population, type of economy, size of city, and income of inhabitants." *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 276 Md. 187, 196 n.5, 349 A.2d 245, 250 n.5 (1975) (emphasis added); accord *Robbins v. Footer*, 553 F.2d 123 (D.C. Cir. 1977).

70. A Michigan study found that only 45% of all claims filed result in indemnity payments, and that this percentage has remained stable for at least a decade. R. Fleming, *supra* note 31, at 14. In the rare case that goes to trial, plaintiffs are successful only 27% of the time, and only about 12% receive an award above \$50,000. Yet only 5% of all claims filed in court actually resulted in a formal trial. MICH. INS. BUREAU REPORT, *supra* note 22, at 11.

71. For example, in Michigan, from 1976 to 1984, "fewer than 20% of claims were closed within two years of filing and only 55% were closed within four years of filing." R. Fleming, *supra* note 31, at 15.

72. According to various estimates, 16% of the premium paid is spent on the legal cost of defending claims, while 44% is paid out in claims. Additionally, 34.5% is spent on production costs and company expenses, and 5% goes for underwriting profit and contingencies. Of the claims paid, from one-third to as much as one-half goes to the plaintiff's attorney, leaving the patient with 22% to 30% of the premium dollar. See, e.g., *Federal Medical Malpractice Insurance Act, 1975: Hearings on S. 482, S. 215, and S. 188 Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare*, 94th Cong., 1st Sess. 453 (1975) [hereinafter *FMMIA Hearings*] (testimony of Richard Lino, Vice Pres., Insurance Serv. Office); see also O'Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, LAW & CONTEMP. PROBS., Spring 1986, at 125, 127 (claiming that 28 cents of each insurance premium dollar was returned to injured patients, of which "only 12.5 cents reimburse the victim for economic losses not already compensated by other sources").

In addition, judicial administration of tort litigation is extremely costly: "[T]he public cost of operating the judicial system . . . has been estimated at . . . about \$300 million . . . for tort claims." Abel, *Review*, *supra* note 69, at 1019 n.52.

73. "The inherent difficulty of proving fault leads to huge transaction costs. . . . The result is that many accident victims are left either totally or relatively unpaid for their losses, while others in similar or identical circumstances are awarded far more than their actual losses." O'Connell, A "Neo No-Fault" Contract In Lieu of Tort: Preaccident Guarantees of Postaccident Settlement Offers, 73 CALIF. L. REV. 898, 899 (1985).

doctors practicing a high-risk specialty.⁷⁴ Both the threat and actuality of litigation cause severe physician "psychic wear and tear."⁷⁵ Fear of potential litigation has caused many physicians "to stop seeing certain types of patients, think of retiring early, and discourage their children from entering medicine."⁷⁶

Commentators have recognized the central importance of ensuring that the doctor-patient relationship remain nonadversarial.⁷⁷ To the extent that the omnipresent threat of malpractice claims encourages the trend towards a less open, more impersonal doctor-patient relationship, both patient and provider suffer.⁷⁸ The patient becomes just another commodity to be processed, while the provider, who entered the often demanding medical profession with high ideals and normative expectations,⁷⁹ becomes a technician, or, even worse, an anonymous though well-paid worker on the health care assembly line.⁸⁰

Malpractice litigation may reduce "physicians' freedom to exercise their own clinical judgment," depriving patients of "the full range of a physician's professional expertise."⁸¹ The threat

74. Charles, Wilbert & Franke, *Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation*, 142 AM. J. PSYCHIATRY 437 (1985).

75. Charles, Wilbert & Franke, *supra* note 74, at 437 ("Although both sued and non-sued physicians reported changes in professional behavior and emotional reactions to both the threat and actuality of litigation, sued physicians reported significantly more symptoms [of stress or affective disorder] than nonsued physicians."); O'Connell, *supra* note 72, at 126 (quoting BOARD OF TRUSTEES, AMERICAN MEDICAL ASS'N, STUDY OF PROFESSIONAL LIABILITY COSTS 101 (1983)). "[T]he biggest cost' of suits brought under the malpractice system is 'the emotional injury that a physician experiences when he or she believes that he or she has done the best possible under difficult circumstances. Decreases in physician productivity as a result of such dysfunction cannot be estimated.'" But see Peters, Nord & Woodson, *An Empirical Analysis of the Medical and Legal Professions' Experiences and Perceptions of Medical and Legal Malpractice*, 19 U. MICH. J.L. REF. 601, 622 (1986) ("[T]he effects of an actual suit seem less than the feared effects anticipated by the unsued.").

76. Charles, Wilbert & Franke, *supra* note 74, at 437. Such responses to litigation may have an adverse effect on health care availability. *Id.* at 440; Peters, Nord & Woodson, *supra* note 75, at 616-20.

77. R. Fleming, *supra* note 31, at 7.

78. "[M]alpractice litigation . . . and the resultant stress on both sued and nonsued physicians may . . . diminish rather than enhance the integrity and availability of medical care." Charles, Wilbert & Franke, *supra* note 74, at 440.

79. Traditionally, physicians held high professional ideals of service and self-sacrifice. See Moore, *supra* note 50.

80. See Sugarman, *supra* note 5, at 584-85.

[A]nother consequence of plaintiff's right to sue in tort is that defendants often perceive litigation as unjustified. . . . [P]rofessionals become demoralized by participation in discovery and trial as well as by unfavorable outcomes.

. . . [M]alpractice law seems to have made cynics out of many doctors and has probably hurt doctor-patient trust relationships.

Id.

81. Charles, Wilbert & Franke, *supra* note 74, at 440.

of litigation may also discourage providers from admitting mistakes, thus allowing malpractice to go undetected where the patient is unaware.⁸² Finally, litigation induces providers to practice inefficient "defensive medicine," that is, superfluous tests and procedures performed in order to foreclose potential tort liability.⁸³ Although the extent of defensive medicine is difficult to gauge, its cost is probably significant.⁸⁴

Defenders of the fault-based tort system point to the deterrent and quality assurance effects of litigation. One such supporter declared: "What is needed is more fault, not no-fault."⁸⁵ The evidence seems to suggest, however, that although medical malpractice tort liability unquestionably generates some socially undesirable costs, it accomplishes little deterrence.⁸⁶ For one thing, strong nonlegal incentives to avoid injuring people exist, including the code of medical ethics and the provider's professional reputation.⁸⁷ Moreover, the relative infrequency of claims and the unpredictability of awards undercut the deterrent value of the possibility of a malpractice action.⁸⁸

82. See R. Fleming, *supra* note 31, at 10.

83. "These practices are said to occur when specific diagnostic and treatment measures are employed explicitly for the purposes either of averting a possible law suit or of providing appropriate documentation that a wide range of tests and treatments has been used in the patient's care." Tancredi & Barondess, *supra* note 20, at 879.

84. Unfortunately, accuracy is limited by the "statistical and definitional difficulties" of studying litigation-related defensive medicine. *Id.* at 881; Robinson, *supra* note 21, at 177. A 1984 study by the American Medical Association (AMA) estimated that defensive medicine increases the national health care bill by 10% each year, or an estimated \$15.1 billion annually. See MICH. INS. BUREAU REPORT, *supra* note 22, at 12. That vast amount is probably greater than any deterrence the current system accomplishes. Some 1975 estimates ranged from \$3 billion to \$7 billion. Tancredi & Barondess, *supra* note 20, at 879. Others have disagreed, arguing that the effects of defensive medicine "are probably small relative to both the cost and the quality of patient care." *Id.*

85. *FMMIA Hearings*, *supra* note 72, at 675 (statement of Sydney Wolfe, M.D., Public Citizen's Health Research Group).

86. "[T]he assumption that negligence is effectively prevented by fear of legal liability and assessment of tort damages has been subject to cogent challenge." O'Connell, *supra* note 72, at 139.

87. Robinson, *supra* note 21, at 176-77; see also Moore, *supra* note 50, at 554. That a physician in the midst of an operation or course of treatment consciously wonders whether he might be subject to malpractice litigation in the event something goes wrong is difficult to believe. Although the physician may be concerned or upset about the threat of malpractice litigation in general, see Charles, Wilbert & Franke, *supra* note 74, it seems more credible that in a core operation or treatment, the physician simply tries his best and uses his normal judgment, however substandard that might be in any individual case. The threat of litigation may well induce the window dressing of defensive medicine, but core operation or treatment decisions are made and actions are taken with little or no regard to potential malpractice litigation.

88. See *supra* text accompanying note 12.

Even in the event of an adverse judgment, almost all providers are insulated by liability insurance, a situation known as "moral hazard."⁸⁹ The medical malpractice insurance rating structure is extremely rigid, with little selective underwriting. Very little rating is based on individualized evaluation or past claims experience,⁹⁰ probably because "the small pool of policyholders and the instability of loss experience over time preclude drawing finer classifications with actuarial credibility."⁹¹ Although the threat of medical malpractice litigation accomplishes some deterrence, such deterrence may result from the regulatory response, not the tort system itself.⁹² A system of first party MMI would generate comparable deterrence by retaining regulatory supervision. When its associated costs are taken into account, malpractice litigation generates insufficient deterrence to uphold it over first party MMI.⁹³

89. P. DANZON, *supra* note 1, at 91.

90. *Id.* at 94.

91. *Id.* at 95. Identifying an insured provider with negligence is damaging to the insured's professional reputation. To rate insureds on the basis of claims experience is unfair when the system is fault based because too few claims go all the way to verdict. Some claims lack any merit at all, while others, although settled, would probably win at trial. Less than 10% of all malpractice claims go to verdict; only 2% are successful. *Id.* at 31, 39. Yet many grievously injured persons never even initiate a claim, and, although valid, many claims go uncompensated. *See supra* notes 36 and 70.

To rate insureds fairly under the present system, either all maloccurrences would have to be taken into account, or only those few that go to an award verdict. Providers would strongly resist the former, while the latter is of little statistical use to insurers.

Under MMI, however, by determining the number of paid maloccurrence claims, an insurer could fairly rate providers for the benefit of its policyholders. *See infra* note 172. The provider's professional reputation is not at stake, since fault is not a criterion; furthermore, the first party insurer has no duty to the provider, who is not a party to the insurance contract.

92. Insurance companies and government regulations have required hospitals to institute review boards to periodically review staff performance, hospital grievance procedures for patients, and other quality control measures. *See, e.g.*, Act approved July 2, 1985, ch. 294, § 2, 1985 N.Y. Laws 686. The most notable regulatory development has been the advent of the Peer Review Organizations (PRO's). 42 U.S.C. § 1320c-1 (1982). *See Note, The Medicare Rx: Prospective Pricing to Effect Cost Containment*, 19 U. MICH. J.L. REF. 743, 759-60 (1986).

Such measures streamline hospital administration and enhance risk management "reporting, investigation, analysis, and recommendations concerning 'incidents' which have potential liability exposure for the hospital or personnel. The activity is dedicated to examining and correcting or eliminating behaviors and procedures which give rise to such incidents." *Id.* at 764 n.108. Nevertheless, such regulations are responses to the inadequacy of tort liability deterrence, not a demonstration of its effectiveness. *See Abel, supra* note 8, at 697-99.

There is no question that doctors abhor being sued and are willing to take significant steps—not always in the public interest—to avert malpractice litigation. Avoiding malpractice litigation, however, must not be confused with avoiding malpractice.

93. Danzon estimates that the current malpractice liability system must reduce the number of negligent injuries by 20% if it is to be worth retaining in spite of its costs,

III. ALTERNATIVE PROPOSALS

Numerous solutions to the malpractice problem have been suggested, ranging from extreme transformation to slight adjustment of the current system. The proposals fall under the sub-headings of tort reform, neo-no-fault, comprehensive national regulation, third party no-fault, and Designated Compensable Events insurance.

A. Tort Reforms

Numerous tort reform measures have been suggested in response to dissatisfaction with current medical malpractice litigation. Although some of these reforms have been adopted by various states,⁹⁴ they have been challenged in state courts as unconstitutional, "with varying degrees of success."⁹⁵ Adopted modifications include "caps" or ceilings on the malpractice victim's noneconomic damage award, structuring damage award payments over a period of years, tightening the statute of limitations for filing malpractice claims, malpractice claim screening panels, elimination of the "collateral source rule" and "ad damnum" clauses in pleadings, abolition of the doctrine of the joint and several liability of tortfeasors, and restrictions on attorneys' contingent fees.⁹⁶

Because these measures are largely a legislative response to the insurance and provider lobbies, not surprisingly, they usually come at the expense of malpractice victims. These and other measures are regressive in that they seek to make malpractice

"rather than simply compensating victims through first party insurance and foregoing all aim at deterrence." P. DANZON, *supra* note 1, at 226. Danzon acknowledges that "a full cost-benefit evaluation is impossible because we cannot measure the number of injuries that are prevented as a result of the additional care exercised by medical providers in response to the threat of liability," *id.* at 225-26, but simply assumes that the current system is worth retaining. This Note argues otherwise. As one commentator noted, "[T]oday's insured malpractice system provides precious little deterrence . . ." Moore & Hoff, *H.R. 3084: A More Rational Compensation System for Medical Malpractice*, LAW & CONTEMP. PROBS., Spring 1986, at 117, 122.

94. See, e.g., California Medical Injury Compensation Act, ch. 1, § 1, 1975 Cal. Stat. 2d Ex. Sess. 3949; Medical Malpractice—Comprehensive Reform, 1985 N.Y. Laws 294; Civil Procedure—Venue, Costs and Fees, Medical Malpractice and Personal Injury Actions, 1986 Mich. Pub. Acts 178.

95. Neubauer & Henke, *supra* note 22, at 64-65.

96. Zuckerman, Koller & Borbjerg, *supra* note 20, at 101-03; R. Fleming, *supra* note 31, at 18-26. Comprehensive discussions of various tort reforms can also be found in ABA REPORT, *supra* note 24, and P. DANZON, *supra* note 1. See also *supra* note 25.

claims more difficult and less remunerative, regardless of the merit of the claim and severity of the injury. Yet, for all these "deprivations of common law rights and remedies otherwise enjoyed by tort victims,"⁹⁷ most commentators agree that such modifications, even if constitutional, "will have, at most, a minor impact on insurance premium costs."⁹⁸

These tort reforms are simply stop gap measures, individually of relatively little significance, but thought to restrain synergistically the growth of malpractice insurance claim costs. Apart from their unfairness, however, the extent of their restraint is debatable. Both health care costs in general⁹⁹ and claim losses in particular continue to outpace inflation.¹⁰⁰

Nevertheless, tort reform legislation is widely credited with abating the 1975 malpractice crisis.¹⁰¹ Now that the same problems of insurance cost and availability have apparently returned, a new wave of tort reform has inundated state legislatures. Thus far, however, the legislatures have failed to recognize the nature of the problem. Like the earlier reforms, these incremental responses fail to address the malpractice problem systematically, and will probably have little comprehensive impact on the problem.

The malpractice problem has two main components: the insurance problem and the litigation problem. The insurance problem stems from the inadequacy of provider spreading of volatile premium costs, not the increase in claim costs. Volatility is a result of the subordination of the insurance industry to the business cycle,¹⁰² while the inadequacy of provider cost spreading is a structural feature of the health care industry.¹⁰³ Neither incremental tort reform nor increased regulation of the insurance and health care industries will significantly affect either aspect of the insurance problem.

The litigation problem involves two basic concerns: "procedural deficiencies" and "secondary costs."¹⁰⁴ Again, incremental

97. Neubauer & Henke, *supra* note 22, at 64.

98. ABA REPORT, *supra* note 24, at vii. According to Natwar M. Gandhi, Chief Economist for the General Accounting Office, "[T]here is no connection between tort reform and rate reduction." Strasser, *supra* note 25, at 40.

99. See, e.g., Neubauer & Henke, *supra* note 22, at 67.

100. See P. DANZON, *supra* note 1, at 225.

101. See, e.g., MICH. INS. BUREAU REPORT, *supra* note 22, at 4.

102. See *supra* notes 45-47 and accompanying text.

103. See *supra* notes 58-63 and accompanying text.

104. The term "procedural deficiencies" refers to the difficulty, delay, expense, unpredictability, and disproportionate compensation typical of such litigation. See *supra* notes 70-73 and accompanying text. "Secondary costs" means those problems associated with malpractice litigation in general, and not directly arising out of any one claim in

tort reform will have little impact upon the resolution of these concerns. Only a significant net reduction in the volume of malpractice litigation and some type of prospective award predictability would ameliorate the situation.¹⁰⁵

B. "Neo-No-Fault" Proposals

Professor Jeffrey O'Connell has written extensively in support of his "neo-no-fault" proposal, which Congressmen W. Henson Moore and Richard Gephardt have attempted to get the House to enact for several years.¹⁰⁶ The O'Connell proposal appears in two forms, one contractual and the other statutory. Both neo-no-fault versions have serious flaws, including the elimination of noneconomic damages, and the preservation of the fault-based, adversarial relationship between provider and patient.¹⁰⁷

particular. Such problems include: doctor-patient adversity; the psychic wear and tear of the threat or actuality of litigation; defensive medicine; restriction of the availability of care for certain patients and of the physician's freedom of judgment; victim ignorance of unrealized claims; and the overall government expense of providing a judicial forum for resolution of malpractice claims. *See supra* notes 36, 72, 74-84 and accompanying text.

105. Only a significant net reduction in the overall volume of malpractice litigation would reduce the basic problem of secondary costs as well as the procedural problem of delay. Tightening the statute of limitations will achieve insignificant reductions, since the vast majority of claims are filed or become apparent within two to three years of the injury. ABA REPORT, *supra* note 24, at 63 n.95.

Ceilings on recoveries reduce overall claim costs slightly, though few awards exceed the high ceilings established. *See id.* at 66. *But see* P. DANZON, *supra* note 1, at 48 (ceilings decrease average settlement by 25%). Because both doctor and hospital are almost always separately and fully insured, however, increasing claim costs are not the problem *per se*. For the same reason, abrogation of the doctrine of joint and several liability should have negligible effects as well. As a restriction on a completely separate, private contract, application of the collateral source rule to subtract first party health insurance payments from the malpractice award is unfair, arguably unconstitutional, *see* Neubauer & Henke, *supra* note 22, at 64, and does not affect the central issue of noneconomic damages. *But see* P. DANZON, *supra* note 1, at 170 (estimating that complete collateral source offset would reduce claim costs by 30-40%). Although slightly reducing settlement size and litigation volume, restricting attorney fees unduly restricts victim access to legal representation. *Id.* at 42-43, 196-97. Such measures probably do little to enhance the uniformity of awards or decrease secondary costs.

106. Originally introduced as H.R. 5400, 98th Cong., 2d Sess. (1984) and later reintroduced as H.R. 3084, 99th Cong., 1st Sess. (1985).

Danzon's elective concept is similar to the "neo-no-fault" proposal. *See* P. DANZON, *supra* note 1, at 208-19.

107. According to the sponsor of the statutory version, "[t]he bill is not a no-fault proposal. To the contrary, it retains the central principle of tort law that compensation should be based on faulty behavior, and it would not provide compensation for all bad outcomes occurring in the course of health care." Moore & Hoff, *supra* note 93, at 117-18.

Under the terms of the Moore-Gephardt bill, the provider may foreclose civil action stemming from an adverse medical outcome by pledging to pay the patient compensation benefits equal to the net economic loss resulting from such injury, plus attorney's fees, within 180 days of the action or inaction giving rise to the personal injury.¹⁰⁸ Payment would be made as the victim incurred economic losses.

Where the provider has no reason to know that a negligent injury has occurred, actual receipt of a claim would trigger the time period.¹⁰⁹ As actually practiced, however, the providers would almost always wait for the claim itself, knowing that it frequently would not arise at all and that, if it did, the provider could claim that the injury was not negligent.

The insurer will make an offer when the plaintiff has a clear-cut case with heavy exposure—potentially high damages—in order to prevent recovery in excess of economic losses. In the marginal cases, however, such offers will not be forthcoming because fault is retained as a criterion for award: if the case is clearly defensible, the insurer retains the option to claim that the likely recovery, as discounted by the probability of success, is zero and refuse to tender an offer.

O'Connell's contractual version is meaningless as well. Under the contractual version, the provider and his insurer would agree "to make postaccident tenders of net economic loss upon the occurrence of a defined event."¹¹⁰ The victim would be free to reject the offer and sue in tort. The problem with the contractual proposal is the inverse of that of the statutory proposal: "Because injured patients retain the option to accept or reject payment of net economic loss . . . those with promising tort claims would opt to sue while only those with a poor prospect for a larger recovery would accept the tender."¹¹¹

At present, however, the provider/insurer can already tender economic damages right at the outset if it so chooses. The advantage of neo-no-fault, according to O'Connell, is that the set-

The contractual proposal is similar, except that the victim retains the option of rejecting the settlement offer and suing; the contract would be between the insurer and the provider. O'Connell, *supra* note 72, at 131-37.

108. H.R. 5400, 98th Cong., 2d Sess. § 2 (1984); *see also* Moore & Hoff, *supra* note 93, at 117-18.

109. Moore & Hoff, *supra* note 93, at 119.

110. O'Connell, *supra* note 72, at 132. O'Connell believes that most malpractice victims with good claims would accept the prompt offer of net economic losses. O'Connell's belief is probably naive, given that many patients already have collateral protection against much of the economic loss and primarily seek damages for pain and suffering.

111. *Id.*

tlement offer is less discretionary under either the contractually elected or statutorily mandated versions of his neo-no-fault proposal; therefore, insurers will no longer hesitate to tender net economic loss out of fear that the offer will provide the plaintiff with a tactical advantage.¹¹²

O'Connell offers no evidence in support of this rather implausible assertion. If there is a reasonable possibility of recovery, plaintiffs' lawyers generally expect an offer of at least net economic loss.¹¹³ Under the current system, the rational insurer makes a maximum offer equal to the anticipated cost of legal defense plus the probability-discounted value of the award. The Moore-Gephardt neo-no-fault bill artificially caps the maximum offer at the amount of net economic losses, regardless of insurer loss exposure on the claim.¹¹⁴ Where the bulk of the economic loss is already covered by collateral insurance sources—probably the majority of cases—victims of provider negligence would receive minimal allotments.

O'Connell's proposal to combine the contractual version with the statutory approach makes little sense. Neither the contractual approach, which gives claimants the discretion to accept the insurer's prearranged offer, nor the statutory approach, which gives insurers the discretion to offer while denying claimants the right to refuse, is fair or sensible, but in combination they cancel

112. O'Connell argues that under neo-no-fault, "an insurer need not fear that the offer to cover net economic loss will be perceived simply as an opening bid or as a signal of weakness, encouraging plaintiffs . . . to hold out for more." *Id.*

113. Neither special legislation nor preaccident guarantees of tenders are needed for insurers to make settlement offers without appearing weak. The insurer need only publicly endorse the neo-no-fault formula of readily tendering economic damages.

The only information an offer of net economic damages can possibly provide to the plaintiff's attorney—who is more concerned with pain and suffering—is that the company feels the case has a reasonable possibility of success. The plaintiff's attorney already knows that—otherwise he would have declined to take the case or dropped it. See P. DANZON, *supra* note 1, at 42-45 (half of all claims dropped without payment, usually because plaintiff's stakes are low relative to costs).

114.

A decision to tender net economic loss will be made whenever the lump sum that the insurer must set aside to pay them is less than the sum of (1) the anticipated costs of a defense and (2) the likely recovery (appropriately discounted for the possibility that a claim will not succeed).

O'Connell, *supra* note 72, at 130.

A rational offer under the current system is usually much higher than the simple offer of economic damages, which may be lower than the insurer's own anticipated litigation costs. At present, the possibility of noneconomic damage awards raises the maximum settlement offer well above the plaintiff's net economic loss.

Under the Moore-Gephardt bill, the maximum offer or "lump sum" is "capped" at the amount of net economic damages. If the claim is worth defending, no offer will be made, but if the calculated "lump sum" is greater than the net economic loss—if the insurer is heavily exposed on the claim—he will tender an offer to foreclose adequate recovery.

each other out. Combining the two approaches would result in pure third party no-fault, which O'Connell and most providers and insurers strongly wish to avoid. Furthermore, as O'Connell himself recognizes, no provider would bind himself by a preaccident commitment if he could have the best of all worlds through a statute.¹¹⁵ O'Connell never adequately explains how such a hybrid system might work, except to state briefly that it would result in fairer subrogation between providers—an issue that is entirely beside the point.

Statutory neo-no-fault is nothing more than a Trojan horse, bearing the total elimination of noneconomic damages in what appears to be the pleasing countenance of no-fault; a closer look reveals a third-party, fault-based tort system. The statutory version gives absolutely nothing to the victim that he does not already have, while severely limiting his recovery. There is no quid pro quo here.¹¹⁶ The plan's backers claim that it would increase the frequency of early payments by limiting their magnitude. Regardless of *arguably* more prompt and frequent payment, and lower litigation costs, the plan ultimately would reduce overall claim losses by severely restricting the amount recoverable. This would greatly benefit liability insurers at the expense of malpractice victims.

Mindful that an outright cap on noneconomic damages might be either politically or constitutionally unacceptable,¹¹⁷ insurers lend their support to neo-no-fault—the effective equivalent of a cap. Neo-no-fault supporters claim the proposal is fair, in that the victims are receiving a valuable quid pro quo. Yet the reality is that any consideration of statutory neo-no-fault offers given to victims in exchange for surrendering their rights to sue for pain and suffering, is either illusory or trivial. Under the present system, bona fide plaintiffs expect insurers to make rational settlement offers; neo-no-fault would artificially reduce the maximum settlement offer to the paltry upper limit of net economic loss. A fortiori, the contractual approach is meaningless; no insurance company would voluntarily agree in advance to waive its right to defend a defensible suit, when it can do so on an ad hoc basis.

Any system of tort compensation should sufficiently compensate victims for pain and suffering. In the first place, such injuries are very real. Compensation makes the person whole, restor-

115. *Id.* at 138.

116. The lack of a genuine quid pro quo indicates the dubious constitutionality of neo-no-fault. See *infra* note 195 and accompanying text.

117. See Neubauer & Henke, *supra* note 22, at 64-65.

ing some of the comfort that has been stripped from the victim's life, and aiding the victim's reintegration into society.¹¹⁸

Furthermore, the emphasis on economic damages places a premium on wage loss, severely reducing recovery by members of the low income class. By taking the income loss of a victim as a measure of the victim's worth, neo-no-fault reinforces society's "differential valuations."¹¹⁹

Giving the defendant the choice of whether or not to make the offer, while stripping the victim of the right to reject it, is clearly unfair. Responding to this apparent asymmetry, O'Connell harshly notes that "injured patients whose net economic losses are paid are being treated very well in comparison with most victims of misfortune in our society, whether from illness, injury, handicap, crime, unemployment, or other mishap."¹²⁰

Obviously, however, the fact that malpractice victims are better off than those unfortunates that society has chosen to ignore does not address the more relevant question, whether malpractice victims have been adequately compensated.¹²¹ Under the neo-no-fault proposal, the answer would be negative.

C. *Broad National Injury Compensation Programs*

The present American tort system favors those victims who can trace their injuries to the fault of another over those who

118.

The victims of bad fortune face severe systemic and personal obstacles to a full integration into communal life. The victim's agony is not merely the physical pain, but the frightening realization that she has been destroyed as a person. Accident victims' self-esteem and confidence in the community 'become as ashes in [their] mouth[s].'

Hutchinson, *supra* note 8, at 763.

119. Abel, *supra* note 8, at 716.

Eliminating recovery for pain and suffering would prejudice the rights of the poor or retired, leaving them "with a clear message that they do not have intrinsic worth since they do not have earnings to be replaced by damages." *AMLA Hearings*, *supra* note 22, at 101 (statement of Patricia Nemore, Staff Attorney, National Senior Citizens Center).

Eliminating noneconomic damages would provide the lowest compensation to those—the poor—who typically experience the greatest risk. See Abel, *supra* note 8, at 717.

120. O'Connell, *supra* note 72, at 129-30.

121. Latin raises the issue of "distributional fairness": "[I]t is not immediately apparent why tort victims should be precluded from obtaining full redress from responsible human agents just because society chooses not to provide complete compensation for other categories of victims." Latin, *supra* note 9, at 742.

To the extent that it is unfair that others who have suffered have had to bear the burden alone, the remedy is to enact broad national health insurance plans. Neo-no-fault, on the other hand, would leave victims largely to their own devices.

can trace their injuries to another, but cannot prove fault. These two classes of victims are favored over "the victims of illnesses or other accidents, ranging from accidents caused by fires or an explosion to a mere slip in the bath-tub."¹²² Yet such differential treatment of equally serious injuries is not self-evidently justifiable.¹²³

In fact, various commentators¹²⁴ and a number of countries have decided that because every member of the community has a right to well-being, the burden of injuries should be distributed throughout the community, regardless of causation and negligence. Those who believe that society ought to compensate the victims of all misfortunes advocate a general accident insurance/compensation fund.¹²⁵ Numerous countries¹²⁶ have adopted general accident compensation plans of various design, although none have gone so far as to compensate mere misfortune, preferring in such instances to rely upon general social security or health insurance mechanisms.¹²⁷

Comprehensive compensation plans replace tort damages with assured compensation of varying degrees, without regard to type of accident or fault. They may be administered as part of a social security program, a national health insurance program, or out of a specific insurance fund to compensate personal injuries.¹²⁸ The government may directly administer the fund, or it

122. Tunc, *Traffic Accident Compensation: Law and Proposals* 51, in 11 *INTERNATIONAL ENCYCLOPEDIA OF COMPARATIVE LAW* 14.92 (A. Tunc ed. 1971).

123. See, e.g., Sugarman, *supra* note 5, at 593 ("[T]ort law bars compensation to victims who, from the perspective of their need, are as deserving as those who succeed through the system.").

124. See, e.g., *id.*; Hutchinson, *supra* note 8, at 757-60 (advocating compensation for "bad fortune" under a general right to well-being).

125. Tunc, *supra* note 122, at 51; see also Sugarman, *supra* note 5, at 592-93.

126. Great Britain, Australia, Sweden, and New Zealand, among others, have some type of comprehensive compensation system. New Zealand is a particularly interesting example, for several reasons. First, it has a common law background. Second, "the system comprehensively covers all personal injury caused by accident," including medical malpractice, and "has completely replaced the common law action for personal injury caused by accident." Brown, *Deterrence in Tort and No-Fault: The New Zealand Experience*, 73 *CALIF. L. REV.* 976, 979 (1985).

A government corporation provides benefits to victims, including "virtually all medical, rehabilitation and funeral expenses, plus income replacement equal to eighty percent of the income actually lost," as well as a small stipend for noneconomic compensation. The system is largely funded from levies on employers and the self-employed, as well as from automobile registration and licensing fees, thereby generating considerable "externalities," or disincentives to deterrence. *Id.* at 983.

127. Considerable literature on these plans exists. See, e.g., Sugarman, *supra* note 5; Fleming, *supra* note 3; Brown, *supra* note 126. For the purposes of this Note, noting the significance of this approach is sufficient.

128. See sources cited *supra* note 127.

may regulate the activities of private insurance companies that provide the actual coverage.

On the whole, these systems have worked well, compensating more victims without straining resources and revenues, and without any indication of adverse effects on risk control.¹²⁹ These comprehensive accident compensation programs are accompanied by generous social security/health insurance provisions in order to reduce both the "liability gap" between compensable and noncompensable injuries, and the related "boundary problem" of distinguishing compensable from noncompensable injuries.¹³⁰ These accompanying provisions provide benefits to those whose injuries are not covered as accidents, such as victims of illness.

A national no-fault program tailored specifically to medical malpractice may be possible apart from a broad, general welfare proposal, or in conjunction with one.¹³¹ During the 1970's, proposals for both broad welfare system expansion,¹³² government sponsored malpractice insurance, and medical malpractice no-fault compensation received serious consideration in this country.¹³³

Replacement of the tort system with a no-fault compensation plan is not without a substantial precedent in this country: workers' compensation. Workers who are injured on the job receive workers' compensation benefits according to specified pay

129. See sources cited *supra* note 127.

130. Sugarman, *supra* note 5, at 628-35.

131.

In Sweden, where there is in place a Patient No-Fault Insurance plan, the plan does not compensate for all medical injuries but for those that are unexpected for the patient, and unforeseeable or improbable in the judgement of the attending physician. Where an injury is a predictable result or risk of a medical encounter, e.g., the consequence of necessary treatment, it is not compensated. Minor injuries are excluded. If the injury could have been prevented, indemnity is provided.

R. Fleming, *supra* note 31, at 30 (footnote omitted).

132. Such proposals called for expansion of the social welfare system along European lines. A central government agency would oversee the payment of health care costs, which would be financed through employment related and general tax revenues. See, e.g., H.R. 13870 and S. 3286, 93d Cong., 2d Sess. (1974) (Comprehensive National Health Insurance Act of 1974).

133. The main effort under this approach to medical malpractice was the proposed federal medical malpractice insurance legislation, which was offered in conjunction with a comprehensive program of medical injury compensation. See *supra* note 26. S. 482 would have put the government in the business of underwriting malpractice insurance. S. 215 would have offered providers the opportunity to participate in an elective no-fault insurance scheme, offering victims of health care maloccurrence the option of either suing in tort or accepting specified no-fault benefits, including up to \$2000 per month for noneconomic damages.

schedules, without regard to fault. Limited first party no-fault insurance for automobile accidents has also been widely adopted.¹³⁴ Yet despite the widespread support for workers' compensation and no-fault auto insurance, there is great resistance to applying no-fault to medical malpractice¹³⁵ or attempting broader, government sponsored social welfare solutions.

Critics have fastened on the costs of financing and administering such programs, and on the theoretical difficulty of identifying or defining the compensable event. The insurance industry has argued vigorously that the cost of a mandatory no-fault medical malpractice insurance plan would be prohibitive because of an inability to eliminate claims for any worsening condition following medical treatment.¹³⁶

Yet determining iatrogenic causation is an empirical question, little different in scope or kind from the fault question the tort system asks—which itself involves questions of causation. The strong American opposition to European-style solutions has deeper roots. Such proposals have little prospect of success in the near future, given prevailing American political attitudes.¹³⁷

134. Although American no-fault auto insurance is generally a third party system based on fault, insureds look to their own insurer for economic damages. Where the other driver is unknown or uninsured, insureds look to their own insurer for noneconomic damages as well.

135. Many of these proposals assume a third party system, in which the patient would still claim against the provider for damages stemming from the maloccurrence. Third party no-fault would only exacerbate the situation by increasing the number of compensable events tenfold though still retaining the essentially adversarial and circular third party (provider inclusive) approach, with its small pool of insureds. See P. DANZON, *supra* note 1, at 208-19.

136. *FMMIA Hearings*, *supra* note 72, at 455-56 (statement of Robert Gilmore, Senior Vice Pres. of Legal Affairs, American Ins. Ass'n). O'Connell agrees:

[G]rave difficulties would obviously confront any system of no-fault insurance that undertook to compensate all those injured by medical treatment. The main problem would be how to define and recognize the insured event. . . . Would it not be difficult in many instances to know whether the patient's injury resulted from treatment or from the condition which sent him to the health care provider in the first place?

O'Connell, *supra* note 72, at 128.

137. In light of the current political push towards "free enterprise" market solutions and contraction of the federal regulatory and welfare state apparatus, proposals to enact national health insurance or place the Department of Health and Human Services in the business of underwriting insurance seem like dinosaurs to many, if not most, legislators and constituents. See Moore & Hoff, *supra* note 93, at 121-22: "Any such scheme would effectively create a very broad health, safety, and life insurance program—a major social undertaking that would raise numerous problems of its own. . . . Such a broad no-fault approach would not and should not be popular in Congress, especially under the present fiscal circumstances."

Broad, federally mandated solutions usually hurt the interests of the low income class by eliminating or severely restricting noneconomic damages. Such solutions also run counter to the deeply ingrained American tradition of state control over tort and insur-

Unlike Europeans, Americans emphasize the importance of individualism and private choices, and recoil from extension of government bureaucracy, intervention, and control,¹³⁸ particularly at the national level.

D. Designated Compensable Events

The most innovative American proposal is the Designated Compensable Event (DCE) approach. As developed in an ABA feasibility study¹³⁹ inspired by a proposed prototype, Medical Adversity Insurance (MAI),¹⁴⁰ the DCE system would promptly compensate certain predefined occurrences, without regard to fault. According to the DCE proposal, for most medical treatments, researchers can isolate a subset of adverse outcomes that are usually avoidable under good quality care, from the general set of significant adverse outcomes. Patients claiming one of the listed injuries would receive scheduled no-fault benefits.¹⁴¹

The DCE study tested the oft-repeated claim that a no-fault malpractice system would have great difficulty identifying the medical accident, as opposed to ordinary care and treatment

ance reform. Law, *A Consumer Perspective on Medical Malpractice*, LAW & CONTEMP. PROBS., Spring 1986, at 305, 318-21. They may thus elicit suspicion from conservatives, insurers, providers (who fear socialized medicine) and even common law tort lawyers (whose pivotal roles may be threatened by the modern trend towards replacement of the common law with an administrative model).

138.

In Europe . . . the compensation picture is today increasingly dominated by the social security system. . . . The United States, on the other hand, seems bent on a very different route. There the federal social security system still makes virtually no contribution to the compensation of accident victims; even the prospects of a minimal national health programme are fading fast under the impact of current inflation and the widespread anti-tax sentiment. The tort system has therefore had to bear a proportionately larger share of the overall compensation effort than in European countries.

Fleming, *supra* note 3, at 268 (footnote omitted).

139. COMMISSION ON MEDICAL PROFESSIONAL LIABILITY, AMERICAN BAR ASS'N, DESIGNATED COMPENSABLE EVENT SYSTEM: A FEASIBILITY STUDY (1979) [hereinafter DCE STUDY].

140. See Havighurst & Tancredi, "Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance, 613 INS. L.J. 69 (1974).

141.

Prepared ahead of time by medical researchers, . . . the lists of these adverse outcomes, or "designated compensable events," would be made the basis of a compensation system in which patients suffering listed outcomes would be paid scheduled benefits from insurance proceeds without the necessity of showing fault on the part of the individual provider.

DCE STUDY, *supra* note 139, at 9.

which fails to ameliorate the patient's condition.¹⁴² DCE seeks to eliminate this causation problem by listing certain outcomes that will be considered compensable.

A panel of expert physicians drew up a fairly comprehensive listing of DCE's arising out of general and orthopedic surgery. The primary criterion used was avoidability. As a concept for analyzing medical intervention, avoidability is meant to have a statistical validity: regardless of any individual outcome, "in a large number of situations the adverse outcome may be highly avoidable."¹⁴³

Under the DCE approach, injuries or errors that are rectified during hospitalization and do not result in continuing disability are noncompensable, for they fail to meet a "minimum threshold of significance."¹⁴⁴ Additionally, those patients suffering unlisted or intentional injuries could sue under the common law; providers would carry both DCE and liability insurance.¹⁴⁵

Although the authors of the DCE study favor compulsory DCE legislation, they theorize that courts would uphold voluntary DCE insurance contracts. The main obstacles to elective DCE insurance would be the constitutional validity of a contractual waiver of one's right to sue,¹⁴⁶ and possible lack of incentive for providers and patients to join a new mode of insurance.¹⁴⁷

Legislatively compelled DCE insurance would schedule damages in advance and assure prompt payment, thereby avoiding significant transaction costs such as litigation expenses and unnecessary anguish. Damages would include medical expenses, lost wages, a schedule of diminished earning capacity, and a schedule of pain and suffering damages for certain DCE's considered susceptible to such damages.¹⁴⁸ Finally, the authors note almost casually that a "patients' option" approach could be taken to supplement the scheduled damages—that "patients

142. See *supra* note 136 and accompanying text.

143. DCE STUDY, *supra* note 139, at 28.

144. *Id.*

145. *Id.* at 71-72, 77-79.

146. *Id.* See generally *infra* note 195 (discussing constitutional issues).

147. As with the contractual (elective) neo-no-fault approach, the provider/insurer would have little incentive to utilize DCE insurance if only he would be bound because the plaintiff would sue in ordinary tort if he had a good negligence case and accept DCE benefits only where he faced an otherwise unfavorable outcome. The only fair way to institute these proposals is to limit equally the range of alternatives available to both defendant and plaintiff.

148. DCE STUDY, *supra* note 139, at 62-65.

could elect, ahead of time, to pay extra for the right to receive add-ons for non-economic harm."¹⁴⁹

The DCE approach ignores the fact that virtually no two injuries are exactly alike, so no two tort cases are exactly alike. The strength of the tort system lies primarily in its ability to adapt general principles of law to an almost infinite variety of fact situations. The DCE list will either be too narrow or too broad. If it is too narrow, then the vast majority of injuries that arise will not be easily assimilated to a DCE. The need for judgment as to whether the actual event is close enough to the designated event to bring the DCE coverage into effect essentially vitiates the usefulness of the concept. On the other hand, if one draws the list too broadly, almost any adverse outcome will be deemed to fall under a DCE, robbing the concept of its substance.

If almost any injury would be compensable, then the system reduces to third party no-fault. Third party no-fault insurance would greatly increase the number of compensable injuries without removing the provider middleman. The system would retain all the current problems of doctor-patient adversity and poor provider cost spreading, magnified by the increased number of claims.

IV. FIRST PARTY NO-FAULT MEDICAL MALOCURRENCE INSURANCE (MMI)

The optimum approach to the medical malpractice insurance problem is the introduction of a system of first party no-fault insurance, similar to the first party component of compulsory no-fault automobile insurance.¹⁵⁰ Under this system, state law would require patients entering a hospital for treatment either

149. *Id.* at 65. This brief suggestion that first party insurance could be used to supplement DCE indicates one of DCE's main failures: it continues to rely on the relatively inefficient third party insurance arrangement.

150. No state has introduced pure no-fault auto insurance; usually, victims with injuries over a certain level of severity can sue the injurer and recover from his third party (liability) insurer. *See, e.g., Newson v. Hertz Corp.*, 164 N.J. Super. 141, 395 A.2d 902 (1978). The analogy to MMI is clearer where the other driver is unknown, uninsured, or underinsured, because most no-fault auto insurance policies contain "uninsured motorist coverage," whereby the policyholder looks to his own carrier for all damages. By the terms of the policy, the award of noneconomic damages (for which the defendant's liability carrier would ordinarily be responsible) is determined by arbitration. *See, e.g., N.J. STAT. ANN. § 17:28-1.1* (West 1985).

to show proof of insurance or purchase a policy covering that particular course of treatment.¹⁵¹

A. *How the System Would Work*

Hospital patients lacking their own prior coverage would either order coverage at the time of admission, or, if qualified, receive subsidized medical maloccurrence insurance. The insurance charge would be treated exactly as any other medical expense on the hospital bill. For example, if the health care recipient was poor or elderly, the federal government would pay the added expense just as it would any other expense covered by Medicaid or Medicare.¹⁵² Once insured, patients would look to their own company for relief for iatrogenic maloccurrence.¹⁵³ If unable to purchase private health insurance, those deemed susceptible to serious illness or hospitalizations could purchase insurance by entering an "assigned risk pool" formed by a state mandated Joint Underwriting Association.¹⁵⁴

Just as most no-fault automobile insurance policies must cross a minimum policy threshold of coverage per claim and per occurrence, first party MMI policies would have to provide at least a statutory minimum level of benefits. Hospital emergency rooms would automatically assign the minimum policy to unconscious or disoriented patients through the assigned risk pool, assuming that the hospital was unable to verify their coverage.¹⁵⁵

151. Like DCE, MMI probably could not be based on an elective model, even with a collateral source rule. Because of the uncertainty of elective systems, providers would continue to carry full liability coverage, with little or no decrease in insurance costs. Too many patients would refuse to buy insurance, thinking they could collect against the provider anyway in the event of injury. *See supra* note 147.

In addition, many hospitals might choose not to require or even offer such insurance. The state would have to intervene to provide for those without access to such coverage or those unable to afford it.

152. Federal legislation would probably be needed to authorize MMI payment by Medicare and Medicaid. Until then, those states enacting MMI legislation would have to provide state MMI subsidization for the needy.

153. Additionally, a spouse or child could be included under a family policy.

154. Such Joint Underwriting Associations (JUA's) would provide insurance to those considered bad risks, or those otherwise unable to obtain insurance in the market. All writers of personal liability insurance within the state would be required to accept their fair share of such assigned risks as a condition of writing insurance in the state. Similar mechanisms are used to provide automobile insurance. Most states set up medical malpractice JUA's during the 1975 crisis, but few remain operative. *See P. DANZON, supra* note 1, at 112.

155. Assuming the patient's name could be determined, a prior record of hospitalization might alert the hospital as to his coverage; the patient might also be carrying his health insurance card. Of course, next of kin could either provide the information or sign

Minimum policy amounts would provide a specified level of noneconomic damages to compensate subsidized or unconscious patients sufficiently.

Poor patients might receive government subsidized minimum policies, though such patients could expand their coverage by adding their own funds to the government subsidy. A different statutory minimum might be appropriate to safeguard minor children, including prenatal newborns; parents could privately purchase whatever level of coverage they could afford, as long as the minimal statutory requirements were satisfied.

In lieu of purchasing a policy, the law could permit competent incoming patients to sign common law tort rights waivers, barring suit for any injury that would ordinarily be covered by first party MMI. Even if constitutional,¹⁵⁶ however, permitting such a loophole would probably be ill-advised because the price of the minimum insurance policy would probably be small as compared to the risk.¹⁵⁷ Instead, to accommodate those who prefer to gamble, a state might offer an even cheaper "medical expenses only" ultra-minimum policy, with fewer benefits than that provided unconscious and government subsidized patients.¹⁵⁸ The state would also have to decide whether to permit "claims made" policies in addition to the standard "occurrence policy."¹⁵⁹

Such flexibility is one of first party MMI's greatest strengths. It allows each individual to value his own damages in advance, which gives insurers a better idea of their overall exposure and permits greater actuarial credibility in determining insurance

for the patient at any desired policy limit. If it were later discovered that the patient had his own coverage after all, the insurance assigned by the hospital would be considered void ab initio.

156. See *infra* note 195.

157. See *infra* note 179 and accompanying text.

158. This Note takes the view that, in general, individual patients are the best judge of their insurance needs. Probably few patients would opt for the minimal coverage. New Jersey permitted auto insurers to offer drivers small rebates in return for waiving some noneconomic damage recovery, N.J. STAT. ANN. § 39:6A-8 (West Supp. 1987), but few insureds seem to have selected this option. See Russo, *Auto-Insurance Reform Is Needed, But Hasty Decisions in Trenton Could Make a Bad Situation Worse*, N.Y. Times, Mar. 2, 1986, §11, at 26, col. 3.

159. The occurrence policy is the traditional medical malpractice policy. It covers any claims arising out of an injury incurred during the term of the policy, regardless of when such claims are filed.

In contrast, a claims made policy covers only claims for injuries incurred and filed during the term of insurance. Such policies burden the provider with the risk of claims made years after the policy's expiration. The use of such policies has increased since the 1975 crisis. P. DANZON, *supra* note 1, at 91-92.

rates.¹⁶⁰ The policy's price would reflect choices as to the nature of the payment—whether lump sum or structured—and particular items covered.

A standard contract arbitration clause would be included, both for questions of contract interpretation as well as for fixing the amount of damages due the policyholder in the event of a hospital accident. Routine arbitration panels, such as those supplied by the American Arbitration Association for uninsured motorist cases,¹⁶¹ would determine almost all disputes, including those in which the insurer queries whether a policyholder's injury is a covered maloccurrence.¹⁶²

The program would specifically exclude informed consent and intentional torts,¹⁶³ as well as ordinary, nonmalpractice tort

160. Professor Ehrenzweig, in developing an early (third party) forerunner of DCE insurance, expressed a similar idea:

As everybody is able to assess his own risk, if he considers his own "worth" in excess of the statutory award, he will be free, and indeed encouraged by hospital and physician, to take additional "hospital-accident insurance." The proposed scheme, which would fix the potential recovery, would thus be fairer to the well-to-do patient than the present system under which the uncertainties of recovery inherent in tort liability and tort insurance make planning of protection impossible.

Ehrenzweig, *Compulsory "Hospital-Accident" Insurance: A Needed First Step Toward the Displacement of Liability for "Medical Malpractice"*, 31 U. CHI. L. REV. 279, 286 (1964).

161. See *supra* note 150. Anyone familiar with such arbitration hearings knows they are vastly more informal and swift than litigation. Without sacrificing due process fairness or fact-finding accuracy, arbitration generates greatly reduced attorney fees while minimizing frustration and animosity. See generally Powsner & Hamermesh, *Medical Malpractice Crisis the Second Time Around: Why Not Arbitrate?*, 8 J. LEGAL MED. 283 (1987).

162. The insured would retain his common law right to sue the carrier for breach of contract, for violating the implied covenant of good faith and fair dealing, and for acting in bad faith—an important check on the insurer, who may neither unreasonably refuse to settle nor cancel the policy in bad faith. See, e.g., *Spindle v. Travelers Ins. Co.*, 66 Cal. App. 3d 951, 136 Cal. Rptr. 404 (1977). If the insurer raised the issue of lapsed or non-existent coverage, the arbitration panel would decide this issue first. If the claimant lost this issue, she could refile against the JUA, upon payment or set-off of the premium that would have been due originally.

163. Such dignitary torts are qualitatively different. They are not merely defects in the health care product, but willful violations of the patient's human rights—the classic substantive concern of tort law. The provider should be held directly responsible for such injuries, perhaps also for injuries involving gross negligence on the part of the provider.

Under first party MMI, informed consent suits would be much less frequent than under the present system. Currently, most such cases are really medical maloccurrence cases in which the patient suffered an adverse medical outcome but cannot prove the provider's negligence. As an alternative, the patient sues for lack of informed consent, really hoping to obtain damages for his adverse outcome.

This loophole in the tort law has distorted the theory of informed consent. Because the harm is not in the bad outcome, but in the failure to properly obtain the patient's consent, the outcome is logically irrelevant to liability. Informed consent derives from the

claims against the provider, such as those arising out of negligent maintenance of the premises. Those bringing such non-MMI tort claims would sue the provider in a regular court of law, as they do under the present system. Therefore, providers would carry supplemental liability insurance¹⁶⁴ to provide coverage for these fringe claims. The applicable class of providers would be established by statute;¹⁶⁵ injuries occurring in an ambulance, a school nurse's office, or a physical therapist's clinic would probably not be included, but those arising out of treatment from a chiropractor probably would.¹⁶⁶

The arbitration panels would separate the sequelae of medical treatment from the sequelae of the patient's condition by applying a standard of avoidability¹⁶⁷ on an ad hoc, claim-by-claim basis, rather than in advance.¹⁶⁸ Under the avoidability test, if a disability was more probably than not attributable to health care management, then provider causation, iatrogenicity, would

tort of battery, not from negligence. For an excellent discussion of informed consent and its present distortion as a negligence action, see Riskin, *supra* note 20.

Some damages should be available to the patient whose consent was not obtained, even if the outcome was perfectly acceptable to her. *Id.* at 603 n.126. Nevertheless, such damages will be relatively low, although varying with the egregiousness of the conduct and the mental distress inflicted. All but the most outraged patients will be satisfied with obtaining no-fault benefits because compensation for adverse outcome is the real motivation behind most informed consent claims.

164. This is the opposite of the DCE proposal, which suggested making first party insurance options available to supplement the provider's third party liability insurance.

165. Implementing MMI in two basic phases may be desirable: the first phase would implement MMI in hospitals and treatment centers; the second would extend the system to individual physicians and cover iatrogenic injuries occurring in the doctor's office. Once applied to individual physicians, a doctor who treated a patient without verifying whether the patient was insured could be held strictly liable in tort for any ordinarily covered iatrogenic injury, barring fraud on the patient's part or an emergency situation. At present, many doctors already require either payment in advance or proof of insurance before rendering treatment.

166. To extend the system beyond iatrogenic injuries occurring in the hospital or doctor's office would mean covering all injuries, regardless of how and where received. Such an extension would require the federal government to step in, abolish tort law, as done in New Zealand, and dictate that everyone be completely insured—an exponential jump from MMI and equivalent to comprehensive national health insurance, something this country is presently unwilling to consider.

167. Although this may seem very novel to Americans, the Europeans applied similar standards as a form of strict liability to automobile accidents, long before no-fault insurance existed. For example, the Italian Civil Code of 1942, Art. 2054, held the driver of a vehicle liable for any damages resulting from the vehicle's use "unless he can prove that he has done everything that was possible in order to avoid the damage." Tunc, *supra* note 122, at 10 n.49; see also *supra* note 131 (Swedish Patient No-Fault Plan).

168. Although MMI arbitration panels could consider all relevant evidence, including statistics, the panels would resolve each claim separately, based on its own particular facts. In contrast, under a DCE system, the determination of avoidability would be made in advance, using statistical formulas and a central research commission.

be established. The panel would presume that medical intervention precipitated the adverse outcome unless the outcome was an unavoidable consequence of a preexisting condition or an unavoidable, reasonably anticipated result of the best treatment alternative.¹⁶⁹

Unquestionably, the boundary problem—distinguishing iatrogenic injuries from those inevitably resulting from the preexisting condition—is significant. Yet MMI boundary problems are no more insurmountable for a fact finder than determinations of negligence or guilt. Courts and arbitrators are accustomed to drawing lines through complicated sets of facts, and the burden of proof never falls equally upon the parties.

The avoidability approach, however, consciously places a heavy burden upon the insurer; proving a negative such as non-avoidability is difficult, and in most cases, the presumption of coverage will prevail. The insurer can better absorb and spread claim costs; it is better able to predetermine the risk a given policyholder presents and match that risk to the price of a given amount of coverage. To lighten the insurer's burden of proof would increase transaction costs by injecting additional uncertainty into the calculation.¹⁷⁰ Having paid for his coverage, the policyholder is entitled to the benefit of his bargain.

169. The term "reasonably anticipated result" means the outcome was actually expected as a standard corollary of that particular treatment or the inevitable result of the malady that sent the patient to the provider in the first place. Thus, if a patient were undergoing radiation treatment for cancer, and as a result, suffered severe side effects, such effects would not be compensable because they were generally unavoidable. For the unavoidable side effect or risk defense to be successful, however, the insurer would need to show that the chosen course of treatment was the most reasonable alternative under the circumstances.

To take another example, assume a patient was hospitalized for triple bypass heart surgery and died on the operating table. If he had had only a one in three chance of survival, the best alternative therapy carried only a one in five chance of survival, and the evidence indicates adherence to accepted medical standards in carrying out the procedure, then the patient's estate cannot claim the prescheduled MMI death benefits.

One might conceive of MMI as applying a common sense standard to medical malpractice: traditionally, a doctor only exonerates himself when he looks the patient (or her survivors) in the eye and says, "Sorry, we did all that reasonably could have been done."

170. Because the proposed standard clearly favors the insured, the insurer would have more incentive to settle promptly. The insurer would also have an incentive to stipulate the issue of maloccurrence, rather than incur needless transactional costs by arbitrating it; the panel would then decide the disputed issues, whether damages or coverage or both. Insurers would probably develop claim screening procedures to "weed out" the claims that clearly should or should not be paid.

Finally, although it would emphasize internal and external regulation to provide quality control,¹⁷¹ MMI would also generate an incentive for hospitals to minimize risk. Because insurers would be better able to figure factors such as provider claims experience and resources into particular policies, hospitals would have an incentive to keep their maloccurrence rate down, or risk losing patients to hospitals with lower insurance costs.¹⁷² First party MMI would provide deterrence without adversity.¹⁷³

B. The Benefits of the System

First party MMI would be more politically acceptable than the other comprehensive proposals. First, it benefits everyone: insurers, patients, providers—even attorneys. By benefiting patients, MMI probably assures its constitutionality. Second, it fits comfortably within the American traditions of favoring decentralized market solutions, rather than massive federal undertakings.

1. *Insurers*— The main problem for insurers under the current system is the small pool of potential policyholders. There are simply not that many doctors, and relatively fewer hospitals. The policyholder pool is contracted further by dividing provid-

171. See *supra* note 92 and accompanying text. For the argument that the present malpractice system generates insignificant deterrence, see *supra* note 93 and accompanying text.

172. Some auto insurance policies are only valid in the state of purchase. Similarly, under MMI, an individual could purchase a policy limiting its coverage to treatment at a specified hospital; should the policyholder need treatment at a different facility, he could purchase a policy specifically for the particular hospital and treatment episode.

Currently, hospitals incorporate insurance increases into their general costs; because consumers pay for their own insurance indirectly, consumers would have no way of comparing insurance costs even if experience rating were widespread.

Under MMI, in contrast, the consumer could be offered a choice of policies with prices depending on the particular hospital covered. Insurers could rate individual health care facilities on the basis of past claims experience, adequacy of resources, and extent of supervisory review. See *supra* note 91. The consumer could choose the hospital with the lowest insurance cost—presumably, the hospital with the best safety record. Applying the HMO concept, an insurance company might decide to offer policies with special “group coverage” rates, allowing coverage for treatment by designated providers within a particular geographical area. The prospect of having the insurance market inform consumers about comparative risks and allowing consumers to choose among providers would motivate providers to take quality assurance measures.

173. Because of the statistical nature of such ratings, individual maloccurrences would have a relatively attenuated impact on the hospital's rating. Providers would co-operate with patients to uncover and pursue bona fide MMI claims because satisfying patients with such good will services makes good business sense.

ers into specialties or categories that embrace various degrees of risk.¹⁷⁴

Quite simply, the larger the pool over which losses are spread, the smaller the burden on each individual within the pool, and the greater the actuarial credibility in determining premium rates. By the law of large numbers, larger policyholder pools and larger claim pools translate into greater certainty of prediction.¹⁷⁵ Add the fact that each MMI policy clearly delineates its loss limits, and the inescapable conclusion is that MMI would increase forecasting accuracy exponentially. Greater accuracy will mean that rates can be closely tailored to fit the actual claims picture, thereby reducing rate volatility.¹⁷⁶

About one-half million physicians practice in the United States,¹⁷⁷ a small number in comparison with the many millions of patients.¹⁷⁸ Under an MMI system, gross premium income from the vast number of policies would overshadow the increased number and frequency of claims. The greater number of MMI policyholders would enable insurers to collect a higher total premium than under the present system because the average price of each MMI policy would be much lower than that of the average malpractice insurance policy.¹⁷⁹ In addition, the insurer's increased premium intake and greater forecasting accuracy would permit more profitable premium income investment, which would supplement lower transaction costs.¹⁸⁰

174. "The current practice of dividing physicians into as many as eight classes for rating purposes is undesirable and should be abandoned. Such a practice has, first, the effect of spreading very great risks over comparatively small numbers of physicians in the higher risk classes." R. Fleming, *supra* note 31, at 28. Even treating doctors homogeneously, however, does not solve the problem of too few physicians.

175. See P. DANZON, *supra* note 1, at 89-90.

176. Cf. *supra* notes 29-31 and accompanying text (poor forecasting that significantly underestimated premium loss ratios partly responsible for large 1975 insurance cost increases.).

177. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE STATISTICAL ABSTRACT OF THE UNITED STATES 1987 90 (107th ed.).

178. Over 18 million people are enrolled in HMO's alone. *Id.*

179. Under the theory of the marginal utility of cumulative losses, see *supra* notes 6-7, more can be charged if the burden is more widely spread. The greater total premium is justified by the utility of allowing losses to be more easily borne. First party MMI seems more expensive than the present system only if one ignores the cost of forcing uncompensated victims to bear their own losses.

180. First party MMI would greatly reduce today's massive litigation expenses. The heavily pro-claimant standard would probably discourage insurer opposition to all but clearly contrived or ineligible claims, while disputed claims would be decided by cost-efficient arbitration. Furthermore, purchasing a composite policy covering health, disability, and medical maloccurrence would largely eliminate the inefficiency of overlapping coverage and permit more accurate insurance rate determination.

2. *Providers*—Instituting first party MMI would be particularly beneficial for health care providers. Under the current system, providers must suffer the opportunity cost of having to put up the premium money, while patients gradually reimburse them in small increments. Under the MMI proposal, providers would no longer carry the initial burden of high malpractice premiums. Although providers would carry a supplemental liability policy, the cost of the supplemental coverage would be a fraction of the present cost of full malpractice insurance because almost all maloccurrences would be covered under the patient's own first party insurance.¹⁸¹

Of incalculably greater importance, however, is that the health care provider will once again be free to do his job without the sword of litigation hanging over his head.¹⁸² First party MMI would eliminate the psychic harm of the threat or actuality of litigation, as well as thawing the currently adversarial doctor-patient relationship.¹⁸³ When patients did claim, they would claim against their own carrier, not against the doctor; MMI claims would not allege fault, only causation. As a no-fault system, MMI would permit the doctor to publicly and impartially evaluate his own work; without the threat of financial or reputational harm, providers would have no reason to withhold information from injured patients, or to subject patients to unnecessary diagnostic procedures. Finally, introducing MMI would encourage greater physician solidarity by eliminating the present specialist/nonspecialist, high risk/low risk malpractice insurance rate classifications.¹⁸⁴

3. *Attorneys*—Attorney support for MMI could be an additional asset. Under the current system, many plaintiffs' lawyers

181. See *supra* note 164 and accompanying text.

182.

The greatest advantage of the proposed scheme would be that it would not only relieve the patient of the economic and emotional strain of protracted litigation requiring difficult or impossible proof, but would also relieve the defendant . . . of a continuous *threat* crippling both sound experimentation and courageous treatment.

Ehrenzweig, *supra* note 160, at 288-89 (discussing the analogous advantages of his proposed "Hospital-Accident Insurance").

183. See *supra* notes 77-80 and accompanying text.

184. "[F]undamentally, such a scheme overlooks the deep interconnections among physicians within the health care system. In the modern system, all physicians are highly dependent on their colleagues, and the care of patients has become the responsibility of networks of physicians who collectively possess the required skills and knowledge." R. Fleming, *supra* note 31, at 28. In other words, why should the doctor who puts the pregnant patient under anesthesia pay a different amount than the doctor who delivers her baby?

shy away from malpractice cases; they are extremely difficult, expensive, and time consuming. The plaintiff often gets little or no compensation, leaving the attorney to absorb the tremendous expenditure of effort and resources.¹⁸⁵

First party MMI would not eliminate the tort system entirely, but where the common law was displaced, attorneys could represent claimants before the MMI arbitration panels. MMI would generate more claims than presently arise, though due to policy limits on recovery, MMI claims would usually be less severe. Attorneys would be more willing to take these smaller cases because their disposition before the arbitration panels would be much less risky and taxing—almost routine.¹⁸⁶

The present system discourages the participation of competent but risk-averse attorneys, yet overcompensates those attorneys willing to take the risk. MMI would save transactional legal costs by employing a more efficient attorney compensation system that replaced contingency fees with post hoc fee awards. Plaintiffs' attorneys would be adequately compensated for their services even if the claim, though bona fide, were unsuccessful. The insurer would pay the documented litigation costs of unsuccessful bona fide claims not exceeding the policy limits, minus a policyholder deductible, and would incorporate the total cost of unsuccessful claims into its policies.¹⁸⁷

185. Because of the risks and expenses of medical malpractice litigation, the plaintiff side is largely the domain of a small group of specialists, because "competition tends to eliminate risk-averse attorneys from contingent fee litigation." P. DANZON, *supra* note 1, at 196.

Even those attorneys who regularly represent medical malpractice claimants are more cautious in their case selection than is generally acknowledged. Because of this selectivity, some victims, particularly those with smaller claims, cannot obtain legal representation. See *id.* at 197; see also L. CHARFOOS, *supra* note 67, at 19-30.

186. See *supra* note 161 and accompanying text.

187. Under a workers' compensation style system, the arbitration panel, or perhaps a separate reviewing board, would award the plaintiffs' attorneys reasonable attorneys' fees based on documented expenses and work. Although the attorney's award would not depend upon the success of the claim, the merit of the claim would be a factor in determining the award. Bringing entirely frivolous claims would subject the attorney to sanctions. Cf. 82 AM. JUR. 2D *Workmen's Compensation* § 646 (1976) ("[F]ees should not be fixed so low that capable attorneys will not be attracted to compensation cases, nor so high as to impair the compensation program; and in individual cases they should be reasonable in view of all the facts and circumstances.").

Alternatively, statutory contingency fee schedules might be reduced to the greater of (1) 10% of gross recovery, or (2) the number of hours worked multiplied by an hourly billing rate (plus unreimbursed expenses).

Post hoc awards would give attorneys incentive to pursue smaller or more difficult claims, on which their opportunity cost might otherwise exceed the statutory allotment. More importantly, MMI fee awards would reduce litigation costs, because under the current system, awards and settlements are inflated to allow for contingency fees. MMI arbitration awards would be tailored to compensate the claimant's specific injuries; the

4. *Patients*—Under a system of first party MMI, many more victims would recover their losses, with much less delay and trauma, than under the current system. The MMI system eliminates transaction costs by eliminating the provider-middleman and directly charging those who currently pay indirectly. Adding a greater incentive to settle quickly, and replacing costly, drawn out and unpredictable litigation with cheap, rapid arbitration, also reduces transaction and psychic costs.

Under first party MMI, patients could choose the policies best suited to their particular needs. Low income patients would no longer have to subsidize the higher damage demands of the well-to-do,¹⁸⁸ but subsidized patients would receive policies providing adequate noneconomic damages. Because relative standards of care would no longer be relevant, MMI would also eliminate the current tort system's discrimination against those who cannot afford the best doctors and facilities.¹⁸⁹

Moreover, rating classifications could be based on one's health, the seriousness of the operation or treatment,¹⁹⁰ and the track record of any specified hospitals and physicians.¹⁹¹ Under the more efficient MMI system, subsidizing unhealthy patients would cost less than the current cost of subsidizing negligent physicians.¹⁹²

plaintiff's legal fees would be awarded separately. The legal fees that, together with the award, exceeded the policy limits, would come out of the claimant's share.

Although insurers would still be responsible for absorbing and spreading both sides' legal fees, by directly accepting the plaintiff's risk, insurers would no longer overcompensate plaintiffs' attorneys for doing so. See P. DANZON, *supra* note 1, at 197 ("[C]ontingent fees on average will appear to overcompensate attorneys by 66 percent for their time spent. . . . [As a plaintiff,] you pay a premium if . . . [you win the case] in order to avoid a loss if . . . [you lose the case].").

188. See Ehrenzweig, *supra* note 160, at 286.

189. See *supra* note 69.

190. Individuals could purchase a policy specific to the upcoming treatment episode, or could purchase advance "umbrella" coverage, specifying a sliding scale schedule of recovery limits depending upon the type of treatment received. Furthermore, the insurers, rather than the provider organization, would have control over the relevant data base (the health and prior claims experience of the insured). Insurers might arrange to have prospective policyholders examined by a physician, as is often required for life insurance contracts.

191. See *supra* note 172 and accompanying text.

192. The current system places relatively little reliance on provider claims experience. See *supra* note 91 and accompanying text. Patients of high risk providers ultimately pay the same insurance cost as patients of low risk providers, in effect receiving a subsidy. Although 58% of all physicians have never been subjected to a claim, 2.5% are responsible for 19.7% of all claims, and 19.3% are responsible for 72.2% of all claims. R. Fleming, *supra* note 31, at 11.

Because MMI premiums are tailored to the individual patient's risk, the cost of subsidizing high risk patients will be lower than the current risk subsidy cost. First, for the healthy to subsidize the unhealthy is probably more efficient than for the non-negligent

Finally, under the current system, many victims of medical malpractice receive little or no compensation,¹⁹³ either because they do not realize that they have a potential claim, or because providers are able to persuade unsophisticated victims to accept relatively paltry settlements. Under first party MMI, however, health care providers would have no reason to hide any information from the patient, because the provider would no longer be held responsible for the injury.¹⁹⁴ The health care provider would resume his traditional role as the patient's fiduciary, free of the mistrust and hostility that are all too common today. Then prearbitration discovery could take place in an atmosphere of candor and neutrality.

C. Political and Constitutional Feasibility

Like its predecessor cousins, workers' compensation and no-fault automobile insurance, first party no-fault medical maloccurrence insurance would be challenged and ultimately upheld on both political and constitutional grounds.

1. *Constitutionality*— Like workers' compensation and no-fault automobile insurance, first party MMI entails the legislative abrogation of certain common law tort remedies, in return for certain other rights and remedies. The legislature can constitutionally abrogate common law rights to further important legislative policies, if doing so yields a genuine quid pro quo.¹⁹⁵

doctor's patients to subsidize the negligent doctor's patients. Second, policy limitations on recovery will limit overall loss. Third, many high risk policyholders will be able to afford their own private, voluntary coverage.

193. See *supra* note 72.

194. See *supra* note 172 and accompanying text. Admittedly, sustaining injury discourages patients from using the same provider in the future, regardless of whether or not the injury was caused by negligence. Yet the reputational damage under MMI would be slight compared to that occurring under the present system, which publicly pits provider against patient, irrevocably destroying many formerly close relationships.

195. The United States Supreme Court has essentially left this issue to the states, to be determined according to state constitutional law. One of the more well-known state constitutional decisions is *Kluger v. White*, 281 So. 2d 1 (Fla. 1973). In *Kluger*, the Florida Supreme Court held the no-fault automobile insurance law's provisions for voluntary waiver of common law tort rights unconstitutional under the state constitution because the legislature failed to provide a reasonable compensation alternative. *Id.* at 4.

The Florida Supreme Court reaffirmed and explained *Kluger* in *Acton v. Ft. Lauderdale Hosp.*, 440 So. 2d 1282 (Fla. 1983). *Acton* upheld the state's workers' compensation laws as "a reasonable alternative to tort litigation." Although workers' compensation "may disadvantage some workers," it extends greater benefits to others and generally "continues to afford substantial advantages to injured workers, including full medical care and wage-loss payments for total or partial disability without their having to endure

In return for abolishing the patient's common law tort rights against the health care provider, the legislature is expanding the range and increasing the probability of patient compensation. If anything, first party MMI would work to the patient's advantage; prior to treatment, the rational patient would choose prompt, satisfactory compensation under MMI over the delay, uncertainty, and anxiety of the current tort system. A written record of arbitration hearings and arbitration fact-findings—for the benefit of reviewing courts—would provide due process protection. Policyholders would also retain their common law rights to sue their insurer for breach of contract and an implied covenant of good faith and fair dealing, and for breach of any fiduciary duties toward the insured.

2. *Political feasibility*—First party MMI is a politically feasible solution to the medical malpractice problem. First, other approaches unduly favor some groups at the expense of others. In contrast, the first party no-fault plan seems to benefit all concerned; no interest group suffers at another's expense.

Second, the plan is in keeping with the American traditions of decentralization, individualism, and entrepreneurial spirit. National uniformity is not required; an MMI program would be administered more efficiently on a state-by-state basis. Nor is centralized control by a giant government agency necessary: rather than placing the government in the business of underwriting insurance, first party MMI encourages competition.

Under the present system, the comparatively small number of providers can support only a correspondingly small number of insurers. First party no-fault would open up a huge insurance market to cater to the needs of the millions of patients suddenly needing no-fault health insurance. Without a monopolistic union, such as a state medical society, to bestow franchises to a single bidder, the vast sales potential would encourage more insurance companies to enter the market. By keeping rates at a minimum, increased competition would benefit the health care consumer.¹⁹⁶

the delay and uncertainty of tort litigation." *Id.* at 1284. The same reasoning seems equally applicable to first party MMI.

196. As a matter of routine, hospitals might arrange to make a variety of policies from various companies available to incoming patients. In view of the particular fiduciary duties of insurance agents and brokers towards policyholders, however, hospitals would more appropriately provide space for insurance agencies to sell the policies, thereby avoiding potential provider-patient conflicts of interest.

A more likely practice would be for hospitals to insist that patients arrange their own private insurance elsewhere, prior to admission, unless the patient was subsidized, a minor, incompetent, or unconscious (including emergency cases), or high risk and, there-

Last, because of its similarity to such pervasive, established types of first party, no-fault insurance as health, disability, automobile, and even life insurance, MMI would not require inordinate changes in the structure or regulation of the insurance industry. MMI coverage could usually be derived from health insurance sources. Current Blue Cross members, for example, might simply be assessed an additional surcharge if they chose to obtain their MMI coverage from Blue Cross. Employee bargaining units could negotiate with their respective employers over the additional coverage as they would any other employee benefit.¹⁹⁷

CONCLUSION

Victims of maloccurrence evoke our sympathies as much as do victims of malpractice.¹⁹⁸ Although it is not yet feasible to spread the burden of all undeserved injuries and afflictions through tax or insurance mechanisms, we can and should shift the burden of losses proximately resulting from a particular treatment episode.

Under a first party medical maloccurrence insurance system, individuals would insure themselves against injuries resulting from treatment and lose their common law right to sue the provider for malpractice. Doctor-patient adversity would be eliminated, and the burden of high malpractice premiums would be removed from the health care provider. By vastly increasing the pool of insureds and delineating the maximum loss exposure, a first party MMI system would permit more accurate actuarial forecasting, and spread avoidable iatrogenic losses more fairly and efficiently than the current, haphazard tort system. And under an MMI system, patients would normally receive prompt, adequate compensation for an expanded range of injuries.

With its lower transaction costs, provider exemption, and broader, more proportionate victim compensation, no-fault med-

fore, unable to purchase private affordable insurance. In such cases, the hospital would assign the patient to the assigned risk pool. The patient would be given a standard minimum policy appropriate for the patient's classification, as mandated by statute, and the policy would be assigned at random to one of the companies participating in the Joint Underwriting Association. See *supra* note 154 and accompanying text.

197. According to Danzon, "more than 85% of private health insurance is employment-based." P. DANZON, *supra* note 1, at 211.

198. R. Fleming, *supra* note 31, at 30.

ical maloccurrence insurance offers a way out of the present medical malpractice quandary.

—*Larry M. Pollack*